

# MORE POWER TO THE PILL: THE IMPACT OF CONTRACEPTIVE FREEDOM ON WOMEN'S LIFE CYCLE LABOR SUPPLY\*

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The release of *Enovid* in 1960, the first birth control pill, afforded U. S. women unprecedented freedom to plan childbearing and their careers. This paper uses plausibly exogenous variation in state consent laws to evaluate the causal impact of the pill on the timing of first births and extent and intensity of women's labor-force participation. The results suggest that legal access to the pill before age 21 significantly reduced the likelihood of a first birth before age 22, increased the number of women in the paid labor force, and raised the number of annual hours worked.

## I. INTRODUCTION

*The movement she [Margaret Sanger] started will grow to be, a hundred years from now, the most influential of all time. When the history of our civilization is written, it will be a biological history, and Margaret Sanger will be its heroine.*<sup>1</sup>

—H. G. Wells, 1931

The release of *Enovid* in 1960, the first birth control pill, afforded U. S. women unprecedented freedom to plan childbearing and their careers. For college women, Goldin and Katz [2002] find that access to oral contraception led to a later age at first marriage and greater representation in nontraditional, professional occupations. But “the pill” may have had durable and far-reaching effects on women's labor market work across levels of attainment.

Relatively little work in economics, either theoretical or empirical, has explicitly examined the impact of oral contraception on women's paid work. Indeed, this line of research may seem relatively unimportant given the compendium of historical, cross-country, and scholarly research that suggests that birth control

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1. Margaret Sanger (1879–1966) is known as the founder of the twentieth century's birth control movement.

mattered very little (cf. Becker [1991, ch. 4]). Well before the advent of the pill, the United States witnessed steady increases in women's labor-force participation and dramatic swings in fertility. In light of this fact, Becker's conclusion summarizes a view held by many scholars: "the 'contraceptive revolution' . . . ushered in by the pill has probably not been a major cause of the sharp drop in fertility in recent decades" [p. 143]. But even if the pill did reduce fertility, recent quasi-experimental research suggests that declining numbers of children can explain remarkably little of the longer-term changes in women's market work [Bronars and Grogger 1994; Jacobsen, Pearce, and Rosenbloom 1999; Hotz, McElroy, and Sanders 1997; Angrist and Evans 1998].<sup>2</sup>

The relative scarcity of empirical evidence on the impact of oral contraception relates to the difficulty of the empirical problem. The pill's introduction in 1960 and subsequent diffusion corresponded to the resurgence of the women's movement, the spread of labor-saving household technologies, the enactment and increasing enforcement of antidiscrimination legislation, and the social unrest associated with the Civil Rights Movement and Vietnam. Moreover, abortion became increasingly available around the time many young women gained access to the pill and may have had comparable effects on their fertility and labor market decisions. Similar to the strategy used by Goldin and Katz [2002], I exploit a source of plausibly exogenous variation to isolate the pill's impact on women's life cycle labor-force participation. This variation arises from broad, state-level changes from 1960 to 1976 that expanded the legal rights of individuals ages 18 to 21. The indirect effect of these legal revisions, however, was to empower unmarried women under the age of 21 to consent to medical care and, by extension, obtain oral contraception without parental consent.

These laws facilitate two types of analysis of the pill's impact. First, they shaped the diffusion of the pill to younger women from 1960 to 1976 and provide a rough time frame over which to look for relevant changes in behavior. Figure I displays trends in first-birth rates by age category since 1940. Although first births

2. Angrist and Evans [1998, p. 474] conclude that since 1950, "the increase in female labor-force participation has been so large that declining fertility can explain only a small fraction of the overall change." Between 1970 and 1990 the same authors suggest that the decline in childbearing beyond the second child among women ages 21 to 35 can account for roughly two percentage points (of the total 16.8 increase) in employment.

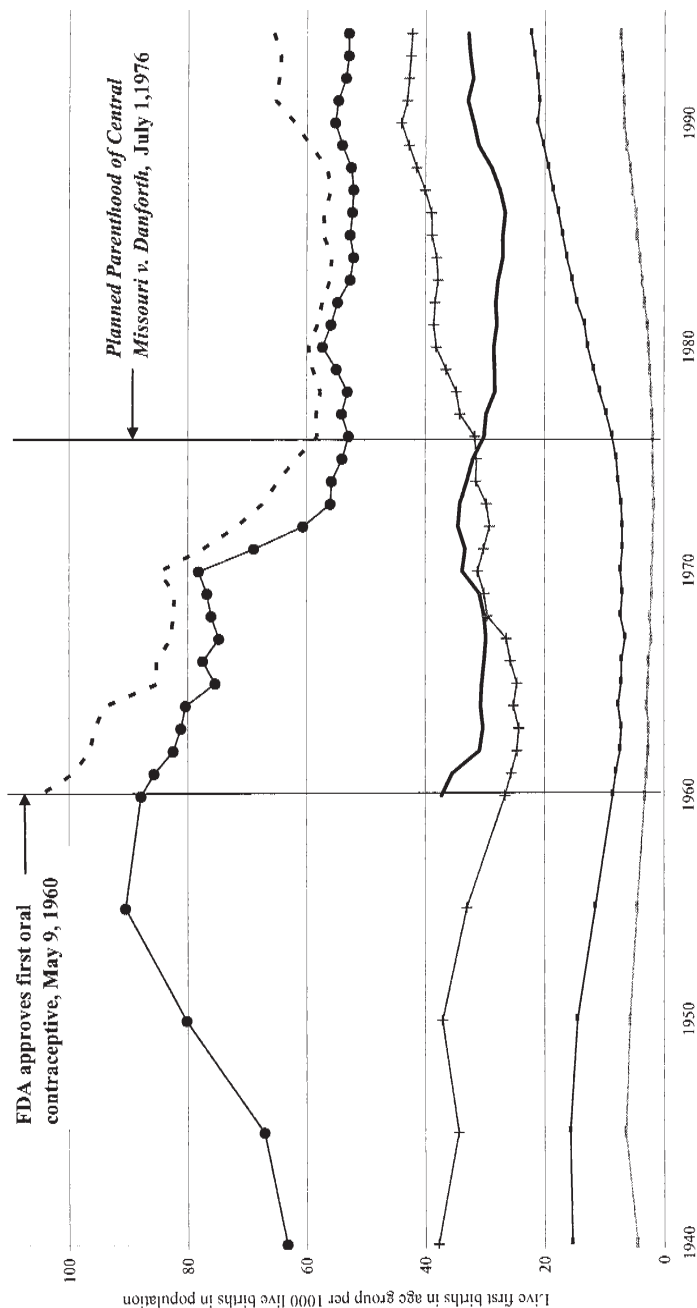


FIGURE I

Live First-Birth Rates by Age of Mother, 1940-1995

First-birth rates are computed as the number of live first births per 1000 women in the appropriate age group.

Source: Division of Vital Statistics, National Center for Health Statistics, Statistical Tables on Births, Table 1 and 2; First-birth rates by Age of Mother, According to Race and Hispanic Origin: United States, Specified Years 1940-1955 and Each Year 1960-1994 [2003].

among younger women increased during the Baby Boom, a marked decline in early childbearing began when the pill was introduced and lasted until 1976, when all unmarried minors in the United States could obtain contraceptives under the law. Notably the largest absolute declines occurred during this period among 18 to 19 year olds, the group of women most likely to benefit from liberalized access laws. In contrast, first-birth rates among 15 to 17 year olds, individuals who were generally too young to benefit, underwent almost no discernible changes.

Changes in the distribution of the age at first birth also correspond closely to the diffusion of the pill. Figure II plots the fraction of women first giving birth in three-year age bins by cohort. For example, the point above age 18 denotes the fraction of women with a first birth within the age bin of 17 to 19. Among women born before 1940 who were too old to benefit from early access, approximately 62 percent of those ever having children report a first birth by age 22. For women born around 1955—almost all of whom had access to the pill under the law—the fraction giving birth by age 22 had declined by 16 percentage points, or roughly 25 percent.<sup>3</sup> Stark differences between cohorts with (1955 to 1960) and without (1933 to 1940) early access to the pill suggest that these changes are not due to preexisting trends. Moreover, there appear to be almost no visible changes in the distributions after 1955, when all young women would have had early access.<sup>4</sup>

A rapid transformation in women's life cycle labor-force participation profiles occurred between the cohorts of 1940 and 1955 as well. As shown in Figure III, women born during the first 40 years of the century tended to withdraw from the labor force during the ages of high fertility. As more women returned to work after their children had grown, increases in the market participation of women over 30, especially married women, drove increases in aggregate participation rates until the 1960s. This pattern reverses with cohorts born after 1940 (cf. Goldin [1990]).

3. The cohort of 1955 is relevant because the U. S. Supreme Court decision, *Planned Parenthood of Central Missouri v. Danforth*, in 1976 ruled against a state's compelling interest to regulate access to contraception based on age alone.

4. The oldest women observed in the 1955 to 1960 birth cohorts were ages 40 and 35, respectively, in the 1995 June CPS, the last survey to ask about the year the first child was born. To the extent that women in these cohorts delayed their first births beyond ages 35 and 40, the fraction of women born between 1955 and 1960 giving birth at earlier ages should be overstated and those delaying understated. Therefore, the inability to observe younger cohorts at older ages tends to make the shift between 1940 and 1955 appear smaller than it is.

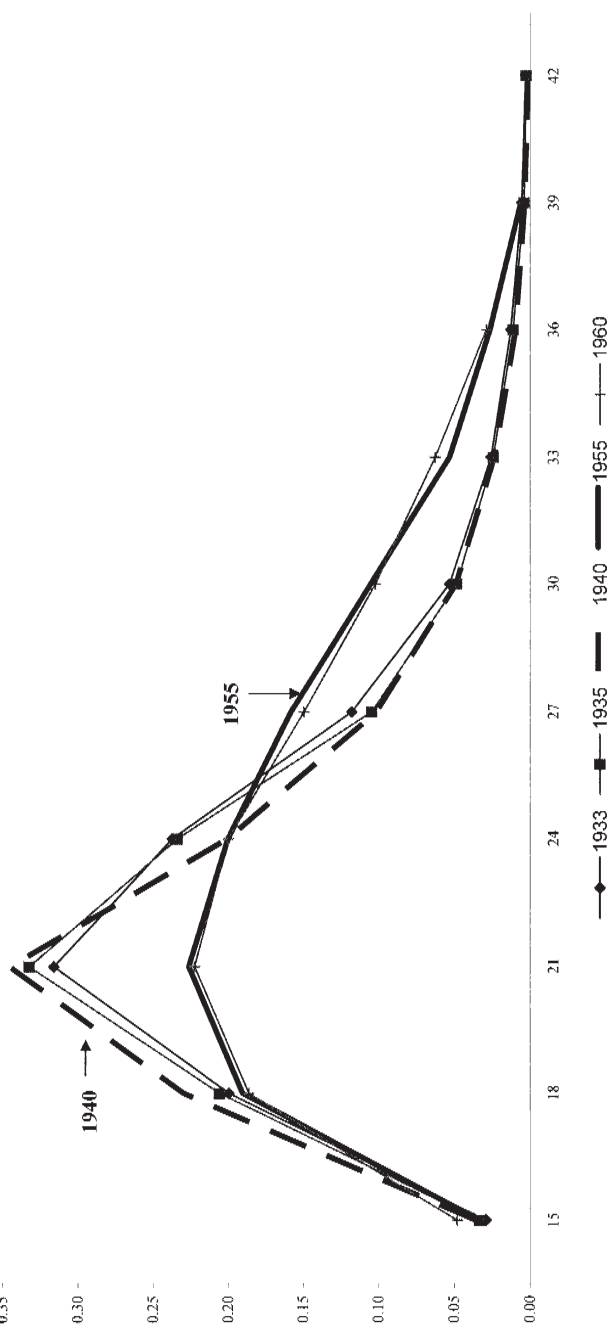


FIGURE II

The Distribution of Age at First Birth, by Cohort

The figure plots the fraction of women (vertical axis) with a first birth at a particular age (horizontal axis). Synthetic birth cohorts are generated by computing the year of birth (reported age from the year of the survey). Sample includes women who were ages 35 to 44 at the time of the survey who had ever given birth.

Source: June CPS 1977-1995.

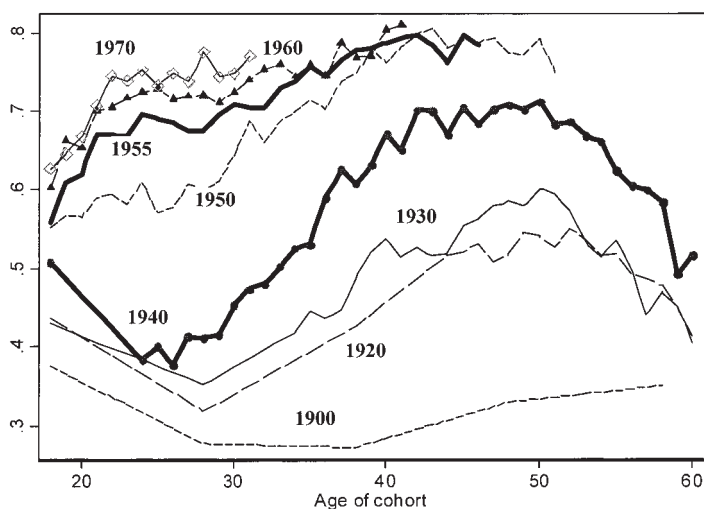


FIGURE III

Age-Specific Labor-Force Participation Rates, by Cohort and Age 1900–1970

Pre-1964 data are averaged over cohorts as in Smith and Ward [1985, Table 1]. For instance, the participation rate for women ages 14 to 19 in 1950 is plotted in this figure as the cohort of 1930 at those ages. Data after 1963 represent participation rates for a single year of birth cohort at the reported age. Synthetic birth cohorts are computed by subtracting the reported age from the year of the survey. Bold lines depict the 1940 and 1955 cohorts. The March sample includes all women not in the military or inmates ages 16 to 60.

Source: 1964–2001 March CPS; for years before 1964, data are from Smith and Ward [1985, Table 1].

For those born in 1955, the “fertility dip” in labor-force participation had completely disappeared. Participation rates were 24 percentage points higher at age 25, and 20 percentage points higher at age 30, than those of women born in 1940.<sup>5</sup> This rapid, intercohort shift in young women’s labor market participation during the twentieth century occurred over the same period as younger and unmarried women gained legal access to oral contraceptives.

While cross-cohort trends are suggestive, the remainder of this paper examines average *within*-cohort effects of early access using implied legal variation by year of birth and state for women

5. Smith and Ward [1985, p. S65] also note that for women born after 1950, there is no observable employment decline over the childbearing years. Goldin [forthcoming, Figures 4 and 5] notes that these trends are borne out for married women as well, although the labor market integration of college graduate women appears to have begun earlier.

born from 1940 to 1955. The estimates suggest that access to the pill before age 21 reduced the likelihood of becoming a mother before age 22 by 14 to 18 percent and increased the extent of 26 to 30 year old women's labor-force participation by approximately 8 percent. At the intensive margin, women with early access worked at least 68 more annual hours at ages 26 to 30. These findings do not challenge the validity of past research on the relationship between the number of children and women's labor supply. Rather, they are consistent with the notion that the pill catalyzed changes in labor-force participation through the mechanism of birth timing. By providing a low cost means of delaying childbearing, oral contraception allowed women to remain in school, pursue longer-term careers, and work more in the paid labor force during ages historically associated with childrearing.

## II. THE THEORETICAL IMPACT OF EARLY ACCESS TO THE PILL ON WOMEN'S LIFE CYCLE LABOR SUPPLY

While a number of relatively effective contraceptive methods were available well before the introduction of *Enovid* in 1960, oral contraception revolutionized the technology of birth control in three important ways.<sup>6</sup> First, the pill constituted the first female contraceptive. A woman could independently decide to take the pill; it did not require the consent or knowledge of men or discomfort to either party during sex. The pill transferred control of contraception, which had long resided with men, to women who bore the high physical and opportunity costs of childbearing. Second, the pill divorced the decision to use contraception from the time of intercourse. This lowered the marginal costs of preventing births during sex to zero and shifted decisions about contraception to times separate from the act of intimacy. Third, the pill's effectiveness far exceeded that of all other methods available in 1960.<sup>7</sup> Whereas most couples regarded pregnancy

6. The withdrawal method, or *coitus interruptus*, had been used well before it was popularized in the United States in Robert Dale Owen's 1831 pamphlet, *Moral Physiology*. A number of other contraceptive methods, such as the condom and diaphragm, had also been adopted before the pill was available [Brodie 1994; Tone 2001]. For a thorough history of the condom, see Brandt [1985] and Valdiserri [1988].

7. From the beginning, *Enovid's* advocates promoted the pill as 99 percent effective. Although numbers on the effectiveness of contraception are dubious at best, Planned Parenthood estimates the failure rates associated with *typical use* of the condoms available today at around 15 percent and the failure rates of today's modern diaphragms at around 16 percent. It is unclear how much of this figure is

risk as part of the cost of intercourse, oral contraception virtually eliminated concerns about unwanted conception [Michael and Willis 1972; Willis 1973; Marks 2001]. By reducing the costs of preventing and timing childbirth, improvements in the technology of birth control may have mitigated the constraints imposed by fecundity on women's labor-force participation. As a result, more women may have entered and remained in the paid workforce.

One might infer from recent studies that the potential effect of the pill on women's fertility and labor-force participation is small. Using biological events to identify the impact of an additional child on women's labor supply, the bulk of compelling research finds only a modest effect (twinning [Bronars and Grogger 1994; Jacobsen, Pearce, and Rosenbloom 1999], miscarriages [Hotz, McElroy, and Sanders 1997], or the sex of children already born [Angrist and Evans 1998]). Using variation in the *number* of births may understate the pill's impact for two reasons. First, only women who chose to become pregnant (or for whom prevention was too costly) enter the sample. The impact of an unexpected birth may be considerably smaller for these women than for those who are childless or are not expecting a child. Second, these studies abstract from the pill's potential effect on labor supply through birth timing.<sup>8</sup> Because couples were fairly accurate at reaching their target fertility before the pill, fairly costless birth timing may be among the pill's most important contributions.<sup>9</sup>

The empirical exercise in this paper allows one to assess the importance of the pill through birth timing using "early access to the pill," defined as unrestricted legal access for unmarried, childless women between ages 18 and 20. This focus may seem narrow,

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attributable to inappropriate use. Less effective spermicides and materials imply that failure rates of these methods would have been much higher in 1960.

8. Klepinger, Lundberg, and Plotnick [1999] provide an excellent review of studies that relate early childbearing to women's outcomes including education, experience, labor-force participation and wages. Most find that early childbearing has a negative effect on each of these outcomes. Miller [2005] and Vere [2004] also examine the impact of birth timing.

9. The pill revolutionized a couple's ability to time childbearing. Primitive methods of birth control included delay of first marriage, longer breast-feeding to delay the return of menses, withdrawal, and the reduced frequency of coitus. Modern alternatives were condoms and diaphragms. Couples anticipated periodic failure of any of these methods, and most employed a variety of methods to hit their target fertility. Before the pill, no method—save abstinence—facilitated the deliberate timing of childbearing.

but decisions at ages 18 to 20 strongly influence young women's career path. Not only do women make choices about human capital investment and occupation, but among women reaching that age before the pill was released, roughly 50 percent had married, and more than 40 percent had conceived by their twenty-first birthdays.<sup>10</sup> During these ages, the risk of pregnancy (for married and unmarried women) not only threatened to disrupt human capital investments in the immediate term [Goldin and Katz 2002] but may have reduced their initial career investments as they expected unplanned, future spells out of the labor market.

Early access to the pill potentially affected women's life cycle labor supply by reducing the costs and increasing the returns to pursuing careers.<sup>11</sup> First, early access reduced the cost of delaying pregnancy in order to make career investments. Young women could stay in the labor market, invest in careers (through formal schooling or training or on-the-job experience), *and* be sexually active (or marry) without the risk of pregnancy. Second, early access increased the expected lifetime returns to career investments by making the timing and number of spells out of the market a deterministic process.<sup>12</sup> Finally, early access may have increased labor supply even among women with no career aspirations per se. For instance, women may have worked more to help their husbands gain more education or reach a certain career stage so as to increase lifetime consumption [Happel, Hill, and Low 1984].

While past empirical studies have emphasized the impact of changes in the number of children on labor supply, the argument here is that early access to the pill may have affected women's work behavior *without* affecting completed fertility. In fact, variation in early access may produce weak, if any, effects on the number of children ever born. After the pill was introduced in 1960, almost all women born later than 1940 obtained access to

10. These figures are based on the author's computations using a sample of women who had married at least once by age 35 and who were born from 1935 to 1940 in the June CPS.

11. The intuition laid out here is consistent with the theoretical models in which rational agents make choices at the outset of their adult lives, given their preferences and abilities, which effectively determine the sequence of childbearing, labor-force participation, and wage outcomes. See Hotz, Klerman, and Willis [1997].

12. Weiss [1986] outlines why expected career interruptions reduce pre-interruption career investments. Mincer and Polachek [1974] cite the expectation of career interruptions as one reason, even after accounting for past interruptions, earnings differ between men and women.

the pill at age 21, by legal emancipation by marriage, or first birth. An ill-timed, early pregnancy could be offset by using contraception to reduce births at ages beyond 21. Thus, women with early access should be equally likely to achieve their target number of children.<sup>13</sup>

### III. IDENTIFYING THE EFFECT OF EARLY ACCESS TO THE PILL USING VARIATION IN STATE LAWS

The nature of the birth control pill as a prescription pharmaceutical renders variation in legal access a convenient tool for studying its impact. While it is questionable whether restrictive state laws were enforced for other forms of contraception, obtaining the pill required a prescription from a licensed physician and sale by a licensed pharmacist.<sup>14</sup> Violations of state laws could be punished with heavy fines, jail time, and possibly the loss of one's professional license [Garrow 1994]. For this reason, restrictions that required a young woman to be a legal adult (over the age of twenty in most states); married, pregnant, or a mother (most states granted "legal emancipation" under any of these conditions); or the legal consent of a guardian imposed binding constraints on young women's decision to obtain the pill.<sup>15</sup>

#### III.A. *The History of Liberalization of Access to Oral Contraception for Younger Women*

During the 1960s and 1970s, the age of legal consent was lowered at different times in different states for reasons largely

13. The exception to this statement is for women who desired no children. A more difficult question is whether early access (not the pill itself) alters the target number of children. Becker argues that birth control should not affect the demand for children [1991, p. 143], for which an empirical proxy is completed fertility. This is also consistent with theoretical models of life cycle fertility, which unambiguously predict that wealth-constant changes in the prices of preventing childbirth or working in any given period will affect the life-cycle timing of births but not necessarily completed fertility (cf. Hotz, Klerman, and Willis [1997, pp. 309–317]).

14. Effective regulation of condoms, for instance, required only that distributors (often gas station clerks) check the age or marital status of those making purchases. A substantial amount of evidence suggests that the illicit distribution of nonhazardous contraceptives over the counter or in vending machines was common before they were legal (cf. Garrow [1994, p. 188]).

15. One final feature of legislative history makes state legal changes a particularly apt quasi experiment. The Comstock Act, which was passed by Congress in 1873, declared the interstate transport or mailing of contraceptives a federal offense. Although the *One Package* U. S. Supreme Court ruling struck down federal bans on the interstate shipping of contraception to licensed physicians in 1936, federal law continued to prohibit individuals from obtaining oral contraceptives by mail from out-of-state. Individuals seeking to obtain the pill would have had to drive across state lines regularly to refill prescriptions and for checkups.

unrelated to issues surrounding contraception or women's rights. Most of these legal changes, in fact, were due either to the expanding rights of legal minors or to changes in the definition of legal "minority."

The trend toward the legal empowerment of minors began well before the introduction of the pill. In 1956 an early Ohio case recognized a "mature minor" doctrine, waiving the requirement of parental consent for medical care if the minor was "intelligent and mature enough to understand the nature and consequences of the treatment" [Paul, Pilpel, and Wechsler 1976, p. 16]. After the pill was introduced, many of these decisions gave physicians latitude to prescribe oral contraception to young women without consulting their parents [Paul, Pilpel, and Wechsler 1974].

As judicial precedents extended the legal rights of minors, the war in Vietnam catalyzed changes in the definition of legal adulthood, or age of legal "majority." Under federal law, one could be drafted for Vietnam at age 18 but could not vote until age 21. This discrepancy in rights and obligations of young men reached national prominence during the 1968 national presidential election. After coming to office, Nixon's support of lowering the federal voting age to eighteen culminated in the ratification of the Twenty-Sixth Amendment to the U. S. Constitution in 1971. At the state level, legislatures began extending the privileges and responsibilities of legal adulthood to eighteen-year old men and women as well.<sup>16</sup> Although extending the right to obtain contraception to younger women had little, if anything, to do with these legislative changes, a lower age of majority empowered them to consent to medical treatment and, by extension, obtain the pill.<sup>17</sup> (In the subsequent discussion I will refer to these states as "age of majority" states.)

During the same period, equally visible and controversial issues were decided in the U. S. Supreme Court. Beginning with the *Griswold* decision in 1965, the Court struck down Connecticut's ban on the use and distribution of contraceptives and declared a realm of "procreative privacy" for married individuals. In subsequent rulings, the right to privacy was held to apply to

16. Several states regarded 18 year old women as legal adults much earlier than the 1970s, while retaining 21 as the age of majority for men. I take these laws to apply to medical consent and obtaining contraceptives.

17. These rights generally included signing contracts; suing and being sued; making wills; inheriting property; holding public office; serving as jurors, policemen, and firemen; marrying and divorcing without parental consent; qualifying for welfare benefits; and attending X-rated movies. In many states, court cases challenged specific provisions of the lower age of majority, but none that I am aware of challenged a young woman's right to consent to medical care.

TABLE I  
DATES OF LEGAL CHANGE GRANTING EARLY ACCESS TO THE PILL

State	Year law effective	Law type
Alabama	1971	MM
Alaska	1960	AOM
Arizona	1972	AOM
Arkansas	1960	AOM
California	1972	AOM
Colorado	1971	MM
Connecticut	1972	MM
Delaware	1972	AOM
District of Columbia	1971	CFP
Florida	1974	AOM
Georgia	1968	CFP
Hawaii	1970	MM
Idaho	1963	FAM
Illinois	1971	MM
Indiana	1973	AOM
Iowa	1973	AOM
Kansas	1970	MM
Kentucky	1968	AOM
Louisiana	1972	AOM
Maine	1971	AOM
Maryland	1967	MM
Massachusetts	1974	AOM
Michigan	1972	AOM
Minnesota	1973	AOM
Mississippi	1966	MM
Missouri	1976	SC
Montana	1971	AOM
Nebraska	1972	AOM
Nevada	1969	FAM
New Hampshire	1971	MM
New Jersey	1973	AOM
New Mexico	1971	AOM
New York	1971	MM
North Carolina	1971	AOM
North Dakota	1972	AOM
Ohio	1965	SC
Oklahoma	1966	FAM
Oregon	1971	MM
Pennsylvania	1971	MM
Rhode Island	1972	AOM
South Carolina	1972	MM
South Dakota	1972	AOM
Tennessee	1971	AOM
Texas	1974	AOM
Utah	1962	FAM

TABLE I  
(CONTINUED)

State	Year law effective	Law type
Vermont	1972	AOM
Virginia	1971	MM
Washington	1971	AOM
West Virginia	1972	AOM
Wisconsin	1973	AOM
Wyoming	1969	CFP

The date of legal change is coded as the earliest year, in which an unmarried, childless woman under age 21 could legally obtain medical treatment without parental or spousal consent. AOM denotes a statutory change in the legal age of majority from 21 to 18 or 19. FAM denotes a change in age of majority (or an existing law) applying to women only. MM denotes a mature minor doctrine that allowed legal infants to consent to medical care as long as they were mature enough to understand "the nature and the consequences of the treatment." CFP refers to a comprehensive family planning statute that allowed or did not expressly restrict physicians from treating legal minors. SC denotes changes at the Supreme Court level: the 1965 *Griswold* and the 1976 *Danforth* decisions. Legal citations available from the author upon request.

Sources: Author's coding using state statutes, DHEW [1974], and Paul, Pilpel, and Wechsler [1974, 1976] and Pilpel and Wechsler [1971].

unmarried individuals in *Eisenstadt v. Baird* and finally, in 1976, to minors. In 1976 *Planned Parenthood of Central Missouri v. Danforth*, the Supreme Court ruled that states lacked a "compelling interest" in using age as the sole criterion under which to regulate contraceptive access. This decision, by no act of popular opinion, rendered the higher age of legal majority inapplicable to the prescription of oral contraception.

I have collected the earliest state laws which empowered unmarried women under the age of 21 to obtain the pill without parental consent.<sup>18</sup> Table I lists the date and source of legal change for each of the 50 states and the District of Columbia. To the extent that these legal changes do not capture changes in women's ability to pay or physician's willingness to prescribe the pill, they are only proxies for early access in practice.

### *III.B. The Validity and Relevance of Liberalization as a Natural Experiment*

In order to use these laws to make inferences about the pill's causal effect, the timing of liberalization should not reflect pre-

18. Liberalization often occurred through the interaction of different legal changes. For instance, liberalization did not occur in Ohio until the U. S. Supreme Court decided *Griswold* which, in practice, struck down Connecticut's Comstock law. However, because Connecticut's statute was more restrictive than Ohio's restrictions on contraception, *Griswold* enjoined Ohio's statute as well. In conjunction with Ohio's mature minor doctrine of 1956, therefore, *Griswold* effectively granted early legal access to contraception.

existing differences in state-level characteristics. The legal history of the liberalization of access suggests little connection to state-level characteristics relating to women's fertility and employment choices.<sup>19</sup> Nevertheless, I evaluate this assumption empirically by generating state-level characteristics for each of the 50 U. S. states and the District of Columbia from the 1960 Public Use Microsample [Ruggles and Sobek 2004], the Survey of Churches and Church Membership [National Council of Churches of Christ 1956], and the record of Casualties in Southeast Asia [National Archives 1997]. For each state, I construct a dependent variable, "time to liberalization," as the number of years that elapsed from 1960, the year the pill was released, until unmarried women under the age of 21 could obtain oral contraception without parental consent in the particular state.

Table II reports point-estimates and robust standard errors from cross-state regressions of "time to liberalization" on selected 1960 state characteristics. The panels group the correlations into four broad categories. Panel A includes the demographic characteristics such as the fraction of the state's population who work in agriculture, is Black, or in different age groups. Panel B includes proxies for education, state fertility norms such as the mean age at first marriage and completed fertility of the older cohorts, poverty rates, fraction Catholic, and the number of Vietnam casualties from 1965 to 1970 as a fraction of the state population.<sup>20</sup> Panel C reports the results of regressions on proxies for household technology such as washers, dryers, and freezers as well as the fraction of households with two or more cars. Panel D includes labor market characteristics for men and women such as labor-force participation, unemployment, and mean wages among 22 to 30 year olds.

The striking feature of Table II is that none of the characteristics is statistically significant, with the exception of the fraction Catholic. A larger fraction of Catholic parish membership in 1952 is associated with a statistically significant delay in liber-

19. Three states that passed comprehensive family planning laws are the exception. By 1972 Georgia, Wyoming, and the District of Columbia passed laws that either explicitly allowed for the treatment of "every patient desiring services" or were broad enough that physicians could treat patients of any age or marital status without liability.

20. The number of casualties in Vietnam is intended to proxy for state-level political pressure to change the age of majority. The date range 1965 to 1970 is chosen because the Twenty-sixth Amendment was ratified in 1971, but the results are not sensitive to small changes in the dates.

TABLE II  
1960 STATE-LEVEL PREDICTORS OF LIBERALIZATION

A. Demographic characteristics						
	Fraction of population			Fraction of women in age group		
	Living on farm	Black	South	15-21	22-30	31-45
Point estimate	-0.804	-2.10	-0.673	10.6	13.9	12.4
<i>S.e.</i>	[5.077]	[3.65]	[1.06]	[7.51]	[9.85]	[24.0]
<i>R</i> <sup>2</sup>	0.000	0.005	0.009	0.059	0.033	0.016
B. Social characteristics						
	Mean years of education for women	Women born 1920-29		Fraction of the population		
		Age of first marriage	Children ever born	In poverty	Catholic	Casualty rate in Vietnam
Point estimate	0.485	-0.217	-18.0	-2.346	5.34	-1.17
<i>S.e.</i>	[0.666]	[0.487]	[12.1]	[3.74]	[2.57]	[1.47]
<i>R</i> <sup>2</sup>	0.009	0.003	0.042	0.010	0.056	0.008
C. Household technology						
	Fraction of households with					
	Radio	Washer	Dryer	Freezer	≥1 car	≥2 cars
Point estimate	-5.58	1.05	-2.75	-1.94	-3.91	12.8
<i>S.e.</i>	[8.16]	[4.09]	[4.70]	[3.69]	[5.89]	[13.9]
<i>R</i> <sup>2</sup>	0.009	0.003	0.010	0.011	0.023	0.006
D. Labor markets						
	Men ages 22-30			Women ages 22-30		
	In labor force	Unemployment	Wages	In labor force	Unemployment	Wages
Point estimate	-12.2	-4.74	0.000	1.80	3.23	-0.001
<i>S.e.</i>	[12.3]	[10.6]	[0.001]	[4.47]	[2.36]	[0.001]
<i>R</i> <sup>2</sup>	0.020	0.004	0.001	0.002	0.021	0.051

The dependent variable is the year in each state, in which unmarried women under the age of 21 could legally obtain contraceptives without parental consent, minus 1960, the year the pill was introduced. Regressors are population weighted state aggregates. The point estimates are obtained by regressing the dependent variable on each state characteristic individually. Results from regressions including all the variables in a given panel do not alter the results. All regressions are unweighted. Robust standard errors are reported in brackets. There are 51 observations in each regression with two exceptions. In Panel B, 49 states are included for the regression with fraction Catholic because the 1952 Survey of Churches and Church Membership only included the 48 contiguous U. S. states and the District of Columbia. In Panel C, Alaska is omitted from the fourth regression, "Freezer," as every household in Alaska reported 1 or more freezers.

Sources: 1960 PUMS [Ruggles and Sobek 2004]. Data on church membership obtained from the National Council of the Churches of Christ in the U.S.A. [1956]. Data on Vietnam casualties obtained from the National Archives [1997].

alization. According to the political history described in Garrow [1994], this relationship might be driven by a strong Catholic lobby against statutes or judicial decisions that *directly* liberalized access to contraception. Because I cannot control directly for fraction Catholic in the analysis (the variable is only available for a handful of years), I include state fixed effects and linear state trends in the analysis and test the robustness of my results by running the analysis on age of majority states only.<sup>21</sup> The lack of a statistical relationship with other potential correlates lends credibility to an empirical strategy that treats legal changes as a valid quasi experiment. It seems fair to conclude that idiosyncratic differences in the regional judiciary and legislatures, the regional politics of minors' rights, and the war in Vietnam resulted in considerable variation in the timing of adoption across states.

Whereas the legal changes appear to be a valid natural experiment to evaluate the effects of early pill access, little direct information exists on their relevance for pill use in practice. As noted in Goldin and Katz [2002], only one publicly available data set in existence, the National Survey of Young Women (1971), contains information on both state of residence and contraceptive use among unmarried teenage women during the appropriate time period. With these data Goldin and Katz find that, in states with liberalized access, pill use was 36 to 40 percent greater among unmarried 17 to 19 year old women.<sup>22</sup> To bolster further the argument that liberalized access to the pill is, indeed, gener-

21. The history of these laws suggests that they were least likely to be influenced by Catholic, anticontraception political interests. For states changing through age of majority, the coefficient on fraction Catholic falls to 1.77 with a robust standard error of 1.70. Repeating the analysis presented in Table II for the age of majority states only yields one statistically significant relationship. A higher fraction of a state's population killed from 1965 to 1970 in Southeast Asia tended to hasten a reduction in the age of majority (correlation = -2.24, *s.e.* = 1.23). This provides empirical support for the political history: higher casualty rates increased pressure to change the legal age of majority, but the timing of these legal changes is not predicted using other state correlates.

22. Qualitative evidence also supports this claim. The journal of *Family Planning Perspectives* provided regular updates from 1968 to 1978 on changes in the age of majority and mature minor doctrines to inform physicians and family planning organizations of the permissiveness of often ambiguous state laws. Moreover, the Department of Health Education and Welfare commissioned a study in 1971 of differences in state laws with respect to fertility control [DHEW 1974]. Subsections of this report on young women's access to contraception regularly begin with references to the legal age of majority in a particular state as well as the other laws. It is also clear from these reports that state welfare agencies and public health departments developed rules regarding contraceptive access based upon legal restrictions in a given state.

ating the observed labor market effects through the mechanism of fertility control, I provide additional evidence that early access facilitated a delay in the age at first birth and that *only* women who delayed childbearing worked more in the paid labor market.

#### IV. DATA AND ESTIMATION RESULTS

The June and March Supplements to the *CPS* consist of repeated cross sections (not annual in the case of the June Supplements) and contain detailed information on individual characteristics including retrospective information on the age at first birth and completed fertility (June Supplements); labor market participation including hours worked in the reference week, and weeks worked in the previous calendar year (March Supplements); and information on current residence (both surveys). For the June sample, I restrict my attention to women ages 36 to 44 at the time of observation as they are most likely to have begun (and completed) their childbearing.<sup>23</sup> The March sample is restricted to women between ages 18 and 44 years old who were not working in the military or incarcerated. I additionally omit observations with allocated values on the dependent variable (cf. Hirsch and Schumacher [2004]) and limit the analysis to women born between 1935 and 1960.

The June *CPS* provide an advantage over the decennial census, because in most years women were surveyed about the year in which their first child was born. The advantage of the March *CPS* lies in their annual collection that allows cohort behavior (defined by year of birth) to be tracked across ages.<sup>24</sup> Several features of these data, however, may minimize the estimated effects. First, the distribution of the pill for reasons other than birth control (e.g., to prevent cramps or regulate menses), otherwise unenforced legislation, the lack of financial accessibility, and cross-state travel to obtain the pill should bias my results toward zero. Neither the *CPS* nor other sources provide a way to account

23. Observing women in each cohort at age 44 would be ideal, but the first birth year is observed for the 1956 and younger cohorts in two years. I have chosen age 36 as a cutoff to retain a reasonable number of observations on year of first birth from these younger cohorts.

24. The decennial census only asks about children currently in the household, so the age at first birth cannot be computed for women with children living out of the household. For the labor-force estimates, decennial census provides snapshots only every ten years of labor-force participation for women born in a given year and, therefore, less information on age-specific labor-force participation by cohort.

for these possibilities or gauge the magnitude of attenuation they introduce, so the estimates should be regarded as conservative. Second, the *CPS* provide no information on a woman's state of birth nor the location of her residence around her twenty-first birthday. It is, therefore, necessary to assume that changes in legal access in the observed residence were relevant to the individual's decisions before age 21.<sup>25</sup> As time passes, women are less likely to be observed in the state where they resided at age 21, and, thus, this source of measurement error may be larger for older women.<sup>26</sup> However, a separate analysis using state of birth and state of residence in the decennial census suggests that the inability to observe state of residence around age 21 leads only to slight attenuation of the estimates.<sup>27</sup>

#### IV.A. *The Impact of Early Access to the Pill on Age at First Birth*

Cross-state heterogeneity in legal access by year of birth facilitates estimation of the pill's average within-cohort effect on childbearing. I estimate equations of the following general form,

$$(1) \quad Y_{ics} = \alpha_0 + \alpha_1 ELA_{ics} + f_s + g_c + \varepsilon_{ics},$$

where  $Y$  denotes a fertility outcome, and  $f_s$  and  $g_c$  denote a set of state and individual year of birth dummy variables. State linear time trends ( $f_s \cdot c$ ), included in some specifications, capture gradually evolving, unobserved state characteristics. Early legal access to the pill,  $ELA$ , is equal to one if women born in year  $c$  would have had access to oral contraception before age 21 in their

25. For example, a 35-year-old woman observed in Massachusetts in 1985 would have been 24 when the Massachusetts liberalized access. Therefore, I code her as without early access, although I do not know where she was living before her twenty-first birthday.

26. Specifically, the estimated long-term effects of early access are based upon the sample of nonmovers. If nonmovers are women who do not take advantage of labor market opportunities in other states, the long-term effects of early access will also be underestimated.

27. Estimates obtained from the 1960 to 1990 Integrated Public Use Micro Samples suggest that measurement error is random and *not* due to, for instance, differential migration of career-minded women to states where they would have had early legal access, or  $ELA$  [Ruggles and Sobek 2004]. Using specifications comparable to those in Table IV and V, I generate two measures of  $ELA$ : one based on state of residence and one based on state of birth. While neither measure provides perfect information on state of residence around age 21, birth state may be a better proxy for the legal environment at that age. Moreover, birth state is not subject to migration bias induced by career decisions. Consistent with attenuation, using state of birth slightly increases the point estimates.

TABLE III  
THE EFFECT OF EARLY LEGAL ACCESS TO THE PILL ON FERTILITY

Dependent variable	1 = First birth before age 22 <sup>a</sup>			1 = Before 19 <sup>b</sup>	1 = Before 36 <sup>c</sup>	Children ever born <sup>d</sup>
	(1)	(2)	(3)	(4)	(5)	(6)
Mean dependent variable		0.497		0.201	0.973	2.38
ELA to pill	-0.071 [0.039]	-0.076 [0.039]	-0.093 [0.043]	-0.011 [0.037]	-0.001 [0.031]	-0.062 [0.086]
Early legal access to abortion			-0.074 [0.057]	-0.086 [0.045]	-0.006 [0.006]	0.242 [0.120]
ELA to pill and abortion			0.057 [0.082]	0.002 [0.065]	0.005 [0.008]	-0.186 [0.114]
Fixed effects	S, C <sup>e</sup>	S, C, SxC <sup>e,f</sup>	S, C, SxC <sup>e,f</sup>	S, C, SxC <sup>e,f</sup>	S, C, SxC <sup>e,f</sup>	S, C, SxC <sup>e,f</sup>
Observations	91791	91791	91791	91791	91791	91791
Log-likelihood	-62118	-61885	-61866	-43968	-9892	-145419

Synthetic birth cohorts are computed by using either the reported year of birth or, when this value is missing, subtracting the reported age in years from the year of the survey. Probits are used for the estimation for columns (1) through (5) and a least squares regression in column (7). The reported numbers are marginal effects evaluated at the mean. Robust standard errors are reported in brackets and are corrected for clustering on state of residence and year of birth cells. All computations are weighted. <sup>a</sup> The dependent variable is equal to one for individuals who had a first birth before age 22 conditional upon giving birth. <sup>b</sup> The dependent variable is equal to one for individuals who had a first birth before age 19 conditional upon giving birth. <sup>c</sup> The dependent variable is equal to one for individuals who had a first birth before age 36 conditional upon giving birth. <sup>d</sup> The dependent variable the reported number of children ever born to women with any children. <sup>e</sup> S and C denote sets of fixed effects for state of residence and year of birth. <sup>f</sup> SxC is a set of dummy variables for state interacted with a linear trend in year of birth. The results for columns (4), (5), and (6) without abortion controls are reported in footnote 32.

Sample: Women ages 36 to 44 who were born between 1935 and 1960.

Source: 1977–1995 June CPS (not including the years 1978, 1984, 1989, 1991, 1993, and 1994 when the survey or information on first birth was not collected).

current state of residence, *s*. *ELA* varies by year of birth, *c*, and state of residence, *s*, for women born from 1940 to 1956, but I also include cohorts born from 1935 to 1960 in order to control for preexisting trends.

Table III reports the marginal effects of early access on various measures of fertility. Probit specifications are used for the binary dependent variables in the first five columns, and the standard errors are corrected for clustering on state of residence and year of birth cells. Columns (1) through (3) present the estimates for the dependent variable equal to one for women giving birth before age 22 (or conceived by age 21) and zero for those having children at 22 or later. The baseline estimate in column (1) (without state trends) implies that early access to the

pill reduced the likelihood of a birth before age 22 by roughly 14 percent ( $-0.071/0.497$ ).<sup>28</sup>

But is the effect causal? Identification of  $\alpha_1$  in this framework comes from variation by year of birth and state of residence. With the inclusion of state and cohort fixed effects, identification is threatened if unobservable factors vary across states and within birth cohorts or within states and across birth cohorts with the proximate pattern of *ELA*. Moreover, in contrast to studies which use cross-state variation in the enactment of laws at the *same* level or branch of government which target a *specific* policy outcome, the laws used in this analysis were enacted at *different* levels of government and targeted *different* policy outcomes. Only indirectly did most of these laws extend access to oral contraception. Precisely this heterogeneity makes it difficult to come up with an alternative omitted variable, correlated with the timing of liberalization, which is not related to early legal access to the pill.

Nevertheless, it is instructive to consider several potential threats to the validity of a causal interpretation. For instance, gradual changes in the fraction Catholic, the growth in the women's movement, or other unobserved trends may have tipped legislators in favor of liberalization and induced women to delay childbearing independently of early legal access. Controlling for these forces directly is not possible in a state-cohort panel. However, the inclusion of state-specific linear time trends should capture unobserved factors within states that evolve smoothly across cohorts. Adding state trends in column (2), however, changes the results negligibly.

Another concern is that the effect of greater early access to abortion from 1970 to 1973 may be confounded with the effect of the pill among the younger cohorts. Directly controlling for early access to abortion in column (3), however, actually strengthens the magnitude and statistical significance of  $\alpha_1$  among cohorts in states without early access to abortion ( $-0.093$ , *s.e.* = 0.043). In this specification, those with early legal access to abortion are 14 percent less likely ( $-0.074/0.497$ ) to give birth before age 22, although the estimate is not statistically significant. As captured in the interaction of early legal access to the pill and abortion, the

28. The inclusion of women without children (zeros for the binary variable for first birth before 22) implies a 16 percent decline in the likelihood of a first birth before age 22.

effects are not appreciably different in states with both types of fertility control. This does not imply that abortion was unimportant, but early access to abortion does not appear to drive the results reported here.<sup>29</sup>

Yet another concern is that the development of a strong women's movement or the diffusion of labor-saving technologies in the household may be related to both legal changes and women's desire to have children and work. One way to test this hypothesis is to examine the correlation of these laws with proxies of a cohort's attitudes about motherhood and childrearing as revealed in their behavior. For instance, because the laws considered in the analysis generally lowered the age of pill access to eighteen, first births by age eighteen (conceptions at seventeen) should not be affected. Finding an effect of *ELA* on a group that should *not* have benefited from liberalization would suggest that *ELA* is picking up changes in other unobservables rather than earlier pill access. The very small and statistically insignificant estimate in column (4) bolsters the case that *ELA* did not affect women who were not generally "treated" with liberalization.

Another way to examine the effect of *ELA* on women's attitudes about motherhood uses measures of completed fertility. Women with and without *ELA* should be equally likely to achieve their target fertility levels, because, as noted previously, virtually every woman after 1960 obtained access to contraception at marriage, at age 21, or after bearing one child.<sup>30</sup> An ill-timed or unwanted birth among those without early access could be easily offset by reducing subsequent births with the pill. Therefore, a strong effect of *ELA* on completed fertility would suggest that *ELA* altered target fertility levels or that *ELA* is really capturing underlying changes in women's attitudes about motherhood and career. The data reject this hypothesis. By age 36, the marginal effect of *ELA* on the likelihood of bearing a child by age 36 among

29. For results on the importance of abortion for general fertility rates (not first birth rates), see Levine et al. [1999], or for labor-force outcomes see Angrist and Evans [1999]. Guldi [2005] provided careful research on legal access to abortion for unmarried women under the age of 21. Early access to abortion is coded as 1970 for Alaska, California, Hawaii, New York, and Washington, and 1972 is coded for Vermont and New Jersey. All other states permitted early legal access with *Roe v. Wade* in 1973.

30. See, for instance, Becker [1991, p. 143] who argues that fertility control should have little effect on the demand for children.

those ever having children falls very close to zero as presented in column (5).<sup>31</sup> Column (6) presents estimates of *ELA* on the number of children at the same age. In states without early access to abortion, the *ELA* appears unrelated to the number of children ever born by age 36.<sup>32</sup>

Finally, because *ELA* varies only for 18 to 20 year olds, one might argue that an effect should appear only for women in that age group. That is, *ELA* should have no effect on the likelihood of first birth by age 24 (conception at age 23). But if relaxing the constraints on young women's choices allowed them to select into different career trajectories, *ELA* may affect optimal birth timing well beyond age 21. The magnitude of this effect should erode, however, as more women select into motherhood. Consistent with this prediction, the effect of *ELA* on first births before age 23 is smaller, but still large and statistically significant ( $-0.086$ , *s.e.* =  $0.044$ ). The effect on first births before age 25, however, is relatively and absolutely smaller in magnitude and no longer statistically significant ( $-0.049$ , *s.e.* =  $0.039$ ). The effect on first births by age 27 is even smaller in magnitude and far from statistically significant ( $-0.021$ , *s.e.* =  $0.034$ ). Therefore, the labor market effects reported later in the paper should be viewed as arising from improvements in the timing of motherhood rather than through reductions in the number of children.

#### IV.B. *The Effect of Early Access on Life Cycle Labor Supply*

The employment data in the March CPS provide annual work information from 1964 to 2001 and allow within-cohort, age-specific labor-force participation effects to be separated from the secular growth in women's market work. One shortcoming of the March data is that smaller states are grouped with others from 1968 to 1976. For this reason, the analysis examines 21 CPS regions (some individual states or D. C.) in order to capture consistent geographic units over the entire period. With this limitation, I redefine *ELA* in CPS region  $r$  in year  $t$  for a woman  $j$  years beyond her twentieth birthday as

$$(2) \quad ELA_{r,t-j} = [P_{r,t-j}]^{-1} \sum_{s \in r} P_{s,t-j} \times 1(Law_{s,t-j}),$$

31. In results not reported here, I find that *ELA* also does not have a discernible effect on selection into childlessness.

32. Without controls for abortion, the point estimate in column (4) becomes  $-0.007$  (*s.e.* =  $0.018$ ) and in column (5) becomes  $0.009$  (*s.e.* =  $0.027$ ). The point estimate in column (6) becomes  $-0.119$  (*s.e.* =  $0.072$ ).

where  $P_{r,t-j}$  denotes the population of region  $r$  in year  $t-j$  and  $P_{s,t-j}$  denotes the population of state  $s$  in region  $r$  in the year  $t-j$ , the date of the woman's twentieth birthday [U.S. Census Bureau, 1967, 1968, 1971, 1981, 1983, 1991, 2001]; and  $1(\cdot)$  is an indicator function equal to one if state  $s$  had a liberal access law in year  $t-j$ .<sup>33</sup> Thus, this variable can be interpreted as the probability that a woman currently residing in region  $r$  in year  $t$  would have had access to contraception before her twenty-first birthday, assuming that she had not moved. This probabilistic approach introduces yet more error into the measurement of *ELA*.<sup>34</sup>

The base specification allows *ELA* to alter the shape of women's labor-force participation profiles through its interaction with a set of categorical age dummies denoted by vector  $\mathbf{A}$ .<sup>35</sup> I estimate equations of the general form,

$$(3) \quad Y_{icar} = \beta_0 + \mathbf{A}_{icar}\beta_1 + ELA_{cr} \times \mathbf{A}_{icar}\beta_2 + f_r + g_c + h_{c+a} + \varepsilon_{icar},$$

where  $c$  refers to the year of birth,  $r$  to the *CPS* region, and  $a$  to the age of individual  $i$ . The fixed-effects  $f_r$ ,  $g_c$ , and  $h_{c+a}$  denote dummies for *CPS* region, year of birth (cohort), and year of observation, respectively. I include region-specific linear time trends ( $f_r \cdot c$ ) in some specifications to capture gradually evolving, unobserved state characteristics that may have changed labor-force outcomes independently of the pill. In this specification, each element of  $\beta_2$  captures the average, age-group specific, within-cohort, within-state impact of early legal access to the pill.

Table IV reports estimates of the marginal effects of *ELA* on the extent of labor-force participation. A probit specification is used for the binary dependent variable for labor-force participation, i.e., worked or looked for work for most of the week prior to the survey. The estimates in columns (1) and (2) (the base-line specification with and without region-specific linear time trends, respectively) are quite similar. With early legal access, the par-

33. *ELA* varies by birth year and *CPS* region, since  $t$  and  $j$  uniquely define a birth cohort. Year of birth is  $t-j-20$ .

34. I examine aggregation error by limiting the analysis to the years 1977–2001, a period over which the *CPS* individually identifies all the states. Controlling for individual state fixed effects rather than *CPS* region fixed effects does not substantially alter the estimates.

35. The elements of  $\mathbf{A}$  are five dummy variables equal to one if a woman falls in the particular age category. The categories are 21 to 25, 26 to 30, 31 to 35, 36 to 40, and 41 to 45. The category 16 to 20 is omitted.

TABLE IV  
THE EFFECT OF EARLY ACCESS TO CONTRACEPTION ON LABOR  
MARKET PARTICIPATION

Dependent variable	Mean dependent variable <sup>a</sup>	1 = In the labor force				
		March CPS				June CPS
		(1)	(2)	(3)	(4)	(5)
ELA to pill × 21–25	0.605	0.003 [0.006]	0.005 [0.006]	−0.003 [0.008]	0.009 [0.009]	−0.048 [0.059]
ELA to pill × 26–30	0.580	0.039 [0.007]	0.042 [0.006]	0.040 [0.009]	0.028 [0.010]	0.005 [0.022]
ELA to pill × 31–35	0.640	0.016 [0.006]	0.019 [0.006]	0.022 [0.009]	0.019 [0.010]	0.004 [0.021]
ELA to pill × 36–40	0.711	−0.002 [0.007]	0.002 [0.006]	0.004 [0.010]	0.007 [0.008]	0.001 [0.023]
ELA to pill × 41–44	0.752	−0.006 [0.008]	−0.003 [0.008]	−0.007 [0.012]	−0.007 [0.008]	0.091 [0.042]
Fixed effects		R, Y, C <sup>b</sup>	RxYear <sup>c</sup>	R, Y, C, RxYear <sup>c</sup>	R, Y, C, RxYear <sup>c</sup>	S, Y, C, SxYear <sup>d</sup>
Age of majority states				X		
Abortion controls <sup>e</sup>					X	X
First birth before 22 <sup>f</sup>						Yes
Observations		733419	733419	245943	733419	103972
Log likelihood		−454635	−454359	−150263	−454341	−59671

Synthetic birth cohorts are computed by subtracting the reported age from the year of the survey. The dependent variable is equal to one if a woman worked in the reference week, looked for a job, or was with a job but not at work. The reported numbers are marginal effects evaluated at the mean. Robust standard errors are reported in brackets and are corrected for clustering on state of residence and year of birth cells. <sup>a</sup> This is the mean of the dependent variable for the estimation sample in each age group in the March CPS. <sup>b</sup> R, Y, and C denote sets of fixed effects for CPS region, year of observation, and year of birth. <sup>c</sup> RxYear is a set of dummy variables for CPS region interacted with a linear time trend. <sup>d</sup> S denotes a set of dummy variables for state of residence. SxYear denotes the interaction of state dummies with linear time trends. <sup>e</sup> Abortion controls are generated in the same manner as in Table III. Early access to abortion is interacted with dummies for the age categories presented in the analysis and triple interaction terms, ELA × early access to abortion × age dummies are included as well. <sup>f</sup> A sample of women from the June CPS who reported a first birth before age 22.

Sample: Women ages 16 to 45 not in the military or inmates born from 1935 to 1960.  
Source: 1964–2001 March CPS, 1977–1995 June CPS.

ticipation rates of women ages 26 to 30 were around four percentage points higher (an increase of 7 percent) and approximately two percentage points higher at ages 31 to 35 at the mean. However, there are no discernible effects for women ages 21 to 25 or among women over age 35. Columns (3) and (4) examine the robustness of these results within the sample of age of majority

states and to the inclusion of measures of early abortion access.<sup>36</sup> The estimates presented in column (4) can be interpreted as the marginal effects of early access to the pill for cohorts reaching the age of 21 for cohorts without early legal access to abortion. In both cases, the results remain within a 95 percent confidence interval of those obtained from the baseline specification.<sup>37</sup>

The paper's evidence, thus far, suggests that the mechanism responsible for changes in women's labor-force participation is the delay in childbearing. If this is correct, then women *with ELA* who did *not* delay childbearing should *not* be observed working more. Said another way, if the labor market participation rates of these women are greater than women without *ELA*, one would suspect that the estimated effects reflect unobserved factors rather than the treatment effects of early access. Column (5) of Table IV uses the limited labor-force information in the June *CPS* to test this.<sup>38</sup> The absence of an effect among women who gave birth before age 22 across ages provides strong evidence for the delay of childbearing as the mechanism linking increased labor-force participation to the pill.

The lack of an effect at ages 21 to 25 is consistent with Goldin and Katz [2002], who argue that *ELA* facilitated greater human capital investment, as well as with the literature linking teenage childbearing to reductions in human capital acquisition through

36. Early access to abortion is defined using the same methodology as *ELA*. The regressions with abortion control include the measure of abortion described in footnote 29 interacted with *A*.

37. I also investigate the effect of Vietnam on women's outcomes independent of changes in the age of majority. If coming of age during Vietnam held different reasons for women to defer marriage, childbearing, or to invest more in formal market work, then changes in the age of majority related to mobilization may be related to women's decisions for reasons other than pill access. On the other hand, draft deferments for being a father or married may have worked to promote earlier marriage or childbearing. After allowing for an age-specific effect of the number of casualties in Vietnam as a fraction of the region's population in a given year (this variable is nonzero from 1965 to 1976), the effect of early access for 26 to 30 year olds and 31 to 35 year olds is quite comparable to the marginal effects presented.

38. The June *CPS* only contain information on state of residence and age of first birth for the years 1977 to 1995 (not including 1978, 1984, 1989, 1991, 1993, and 1994). Because there are fewer cross sections in the June *CPS*, the point estimates for younger age groups represent effects among the younger cohorts, and the point estimates for older age groups represent the effects among the older cohorts (rather than an average over all of the cohorts in each age group as in the March *CPS* estimates). For women with a first birth after age 22 conditioning on age of first birth, the point estimates and standard errors on *ELA* interacted with each age group dummies in column (5) of Table IV are -0.011 (*s.e.* = 0.043) for ages 21-25, 0.027 (*s.e.* = 0.016) for ages 26-30, 0.015 (*s.e.* = 0.015) for ages 31-35, 0.016 (*s.e.* = 0.016) for ages 36-40, -0.002 (*s.e.* = 0.018) for ages 41-44.

labor-force participation (cf. Klepinger, Lundberg, and Plotnick [1999]). If younger women with early access spent more time in school, then they may not work more. This is supported using a *CPS* question about what the respondent was doing "most of last week." From 1964 to 1988 an individual not in the labor force could respond that the reason for not working for pay was that she was "in school." For women ages 16 to 30, I estimate a probit model using the baseline specification in Table IV with a binary dependent variable equal to 1 if a woman reported being "in school" rather than being in the paid labor force. I replace the five-year age dummies with six, two-year age dummies and their interaction with *ELA* for women ages 18 to 20, 21 to 22, and so forth. *ELA* is associated with a 0.043 (*s.e.* = 0.008) percentage point increase in enrollment among women 18 to 20, 0.047 percentage point increase at ages 21 to 22 (*s.e.* = 0.008), and 0.023 percentage point increase at ages 23 to 24 (*s.e.* = 0.005).<sup>39</sup> There appears to be no effect on enrollment over age 24.

The lack of a difference in labor-force participation between women with and without *ELA* at older ages is more difficult to assess using the *CPS*. First, women who bore their children during their twenties may be returning to the labor market during their later thirties. Thus, the econometrician would observe a falling difference in labor force outcomes between the two groups as more women without *ELA* reenter the labor force. Second, as women age, they are less likely to reside in the same state as at age 21, so measurement error due to migration may obscure the effect as women age.

Changes in the intensity of labor supply underscore the possibility of changing career investment in the form of market work as well. Table V presents the regression results for three dependent variables: hours worked, weeks worked, and the product of the two that provides a proxy for annual hours worked.<sup>40</sup> Across the three dependent variables, the pattern of results is quite similar to those at the extensive margin. The impact on the three measures is largest at ages 26 to 30, when women with early legal access appear to be working 68 to 107 more annual hours (or 1.7

39. The cell means for the dependent variable "In school" among workers not working for pay is .258 for women ages 18 to 20, 0.096 for ages 21 to 22, 0.029 for ages 23 to 24, 0.018 for ages 25 to 26, 0.014 for ages 27 to 28, and 0.011 for ages 29 to 30.

40. As the March *CPS* reports intervals for weeks worked before 1976, I use the interval means suggested by Unicon in the estimation.

TABLE V  
THE EFFECT OF EARLY ACCESS TO CONTRACEPTION ON INTENSITY OF MARKET WORK

Dependent variable	Hours worked last week <sup>a</sup>			Weeks worked last year <sup>b</sup>			Implied annual hours <sup>c</sup>		
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
ELA × 21–25	0.206 [0.229]	–0.442 [0.389]	0.535 [0.361]	–0.257 [0.257]	–0.625 [0.427]	0.044 [0.396]	7.81 [10.4]	–19.3 [17.5]	28.3 [17.9]
ELA × 26–30	2.34 [0.285]	1.68 [0.497]	1.5 [0.411]	2.34 [0.320]	1.66 [0.525]	1.43 [0.481]	107 [13.4]	73.5 [23.8]	68.5 [20.8]
ELA × 31–35	1.51 [0.270]	1.63 [0.441]	0.975 [0.425]	1.73 [0.308]	1.54 [0.494]	1.33 [0.493]	71.2 [13.4]	72.1 [22.6]	50.3 [21.3]
ELA × 36–40	0.555 [0.268]	0.905 [0.457]	0.422 [0.334]	0.544 [0.309]	1.01 [0.507]	0.233 [0.412]	29.1 [14.1]	47.0 [25.0]	18.2 [17.3]
ELA × 41–44	0.464 [0.298]	0.871 [0.497]	0.512 [0.352]	0.316 [0.358]	0.332 [0.614]	0.203 [0.371]	29.4 [15.6]	46.9 [26.8]	31.2 [18.3]
Fixed effects	R, Y, C, RxYear <sup>d</sup>	R, Y, C, RxYear <sup>d</sup>	R, Y, C, RxYear <sup>d</sup>	R, Y, C, RxYear <sup>d</sup>	R, Y, C, RxYear <sup>d</sup>	R, Y, C, RxYear <sup>d</sup>	R, Y, C, RxYear <sup>d</sup>	R, Y, C, RxYear <sup>d</sup>	R, Y, C, RxYear <sup>d</sup>
Age of majority states	X			X			X		
Abortion controls	X			X			X		
Observations	730384	244661	730384	733419	245943	733419	730384	244661	730384
Adjusted R <sup>2</sup>	0.066	0.056	0.066	0.073	0.058	0.073	0.088	0.079	0.088

Synthetic birth cohorts are computed by subtracting the reported age from the year of the survey. All computations are weighted. Robust standard errors are reported in brackets and are corrected for clustering on state of residence and year of birth cells. <sup>a</sup> The number of hours that were worked in the CPS reference week. <sup>b</sup> The number of weeks that were worked in the previous calendar year. <sup>c</sup> The product of <sup>a</sup> and <sup>b</sup>. <sup>d</sup> R, Y, and C denote sets of fixed effects for CPS region, year of observation, and year of birth. RxYear denotes a set of dummy variables for CPS region interacted with a linear time trend.

Sample: Women ages 16 to 45 not in the military or inmates born 1935 to 1960.

Source: 1964–2001 March CPS.

a. The number of hours that were worked in the CPS reference week. The variable mean at ages 21–25 is 19.2, at ages 26–30 is 18.6, at ages 31–35 is 20.7, at ages 36–40 is 23.7, and at ages 41–44 is 26.7.

b. The number of weeks that were worked in the previous calendar year. The variable mean at ages 21–25 is 27.0, at ages 26–30 is 26.5, at ages 31–35 is 29.4, at ages 36–40 is 32.2, and at ages 41–44 is 35.9.

c. The product of hours worked last week and weeks worked last year. The variable mean at ages 21–25 is 800, at ages 26–30 is 819, at ages 31–35 is 944, at ages 36–40 is 1117, and at ages 41–44 is 1283.

to 2.7 more full-time weeks per year). This suggests that cohorts with early legal access acquired at least 650 more hours of work experience per person by age 35 than their peers without early access.<sup>41</sup> *ELA* appears to have no effect on work intensity at ages under 24 or above 36. Because these estimates are conditional upon being in the workforce, selection makes them difficult to interpret. On the one hand, negative selection into the labor force at the extensive margin would tend to bias the estimates for hours and weeks worked downwards for younger women (as the most productive and educated women were already working). On the other hand, early access may have affected selection in a less straightforward manner, as women reorganized the traditional sequence of childbearing and work to suit the pursuit of both family and career. While the *CPS* data do not allow me to weigh the relative importance of these possibilities, more research on the changing age structure of women's employment and childbearing and its relationship to contraception is certainly warranted.

#### *IV.C. The Effect of Early Access through Career Choice and Human Capital Accumulation*

Labor market participation effects at the extensive and intensive margins are consistent with the notion that *ELA* to the pill changed women's lifetime career paths. Economic theory suggests that these effects may arise from greater human capital investments and changing career choices [Goldin and Katz 2002]. Using the limited information on occupation in the *CPS*, I generate eight, crude but comparable career dummies as well as a set of dummy variables for highest grade attended in school before 1992. The inclusion of only occupation dummies interacted with *A* in equation (3) reduces the size of the effect on *ELA* at ages 26 to 30 on women's labor-force participation by around two-thirds (extent: 0.013, *s.e.* = 0.008, annual hours: 46.0, *s.e.* = 23.1).<sup>42</sup> The inclusion of only education dummies interacted with *A* reduces the point estimates for the same age group by approximately

41. Cohorts of women who would have been in the labor force without *ELA* should have gained 68.5 additional annual hours for five years during their late twenties and 50.3 during their early thirties for a total of 594 hours. In addition, the number of women working in cohorts with *ELA* was larger because labor-force participation increased at the extensive margin as well adding another 58 hours.

42. These figures are obtained by running the specification in column (4) of Table IV and column (9) of Table V.

one-third (extent: 0.026, *s.e.* = 0.009, annual hours: 56.0, *s.e.* = 18.7). The inclusion of both occupational and education dummies interacted with *A* drives the effect of *ELA* on being in the labor market to zero, and the effect on annual hours worked remains only marginally statistically significant at 43.0 (*s.e.* = 22.4).<sup>43</sup> It seems fair to conclude that net of changes in occupation and education, *ELA* appears to have had little effect on women's market work. These results reinforce the claim that changing career trajectories, resulting from delay in childbearing, constitute the primary mechanism connecting early access to the pill to increases in labor-force participation.

## V. MORE POWER TO THE PILL

Economists have been hesitant to credit fertility control with shaping women's postwar labor supply. Instead, studies have emphasized real wage growth for women [Smith and Ward 1985, 1989; Goldin 1990], falling discrimination including the elimination of marriage bars [Goldin 1988, 1990], rising demand for labor in the clerical sector [Goldin 1984; Smith and Ward 1985], the growing demand for highly skilled workers [Black and Juhn 2000; Welch 2000], and the diffusion of labor-saving technologies within the household [Greenwood, Seshadri, and Yorukoglu 2005]. This paper's results do not discount the importance of these factors in reshaping women's employment decisions. On the contrary, oral contraceptives might have mattered very little in the absence of these changes. It was, however, within the social, legal, and economic context of the 1960s and 1970s that the pill provided a powerful tool for women wishing to capitalize on the emerging labor market opportunities.

While this analysis can provide only a rough approximation of its importance, oral contraception appears to have had large and permanent effects on young women's fertility and labor market activity. Using plausibly exogenous changes in laws restricting the age at which young women could consent to medical care, I find that cohorts with earlier legal access to the pill had fewer births before age 21 and worked more for pay during their late twenties and early thirties. The estimates are surprisingly strong

43. The remaining effect on annual hours worked may be due to imprecise proxies for occupation in the *CPS*.

and quite robust, despite the fact that data limitations—including the inability to observe whether laws were enforced, whether young women could pay for the pill, and whether doctors actually prescribed pills to younger women—tend to attenuate the estimates.

There are other reasons to believe that the estimates of the pill's impact are conservative. Reliance on variation in *early access* to the pill does not allow the effects of access to the pill at age 21 (or later) to be estimated. Furthermore, within-cohort comparisons do not account for the possibility that greater access to the pill had spillover effects across cohorts within states or within cohorts across states. For instance, early access to the pill may have altered norms governing women's labor market roles in addition to its effects on individual women's decisions. In the estimation, however, these effects are captured in the year of birth fixed effects and state-trends. Yet even these conservative estimates suggest that from 1970 to 1990 early access to the pill can account for 3 of the 20 percentage point increase (14 percent) in labor-force participation rates and 67 of the 450 increase in annual hours worked (15 percent) among women ages 16 to 30 year olds.<sup>44</sup>

Broadly speaking, this paper advances the hypothesis that greater fertility control contributed to the boom in young women's market work from 1970 to 1990. More importantly, the findings provoke larger questions about the influence of better birth control on many other outcomes of interest, including family formation, childrearing, education, and wage growth. Further study of the importance of oral contraceptives—as well as other methods of reliable contraception—may advance our understanding of the origins of the second demographic transition and the epochal changes in women's work over the course of the twentieth century.

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44. Using the estimates from the baseline model in equation (3) (including abortion controls), I generate counterfactuals of labor-force participation by assuming that no state had a law that permitted early legal access. That is, I replace *ELA* with zero and predict the baseline model. This allows me to capture how changing cohort size or year specific effects (like *Roe v. Wade* or the U. S. business cycle), state trends and the secular increase in cohort participation would have affected women's participation in the absence of liberalization. I then attribute the difference in the simulated and the observed participation rates to early access. As with any counterfactual computation, these numbers should be viewed cautiously.

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## ASPE ISSUE BRIEF

# The Cost of Covering Contraceptives through Health Insurance

February 2012

### About This Issue Brief

This brief reviews the literature on the cost of contraceptive coverage in private and public health insurance programs. This brief was written by John Bertko, F.S.A., M.A.A.A., Director of Special Initiatives and Pricing in the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services; Sherry Glied, Ph.D., Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services (ASPE/HHS); Erin Miller, (ASPE/HHS); Adelle Simmons (ASPE/HHS); and Lee Wilson (ASPE/HHS).

*This Issue Brief is available on the Internet at:*  
<http://aspe.hhs.gov/health/reports/2012/contraceptives/ib.shtml>

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## Summary

In August 2011, the Department of Health and Human Services (HHS) published Guidelines on Women's Preventive Services that will require non-grandfathered health insurance plans to cover certain recommended preventive services for women, including contraceptive services, without charging a co-pay, co-insurance or a deductible beginning in August of 2012. The Guidelines are based on recommendations to the Department from the Institute of Medicine, which relied on independent physicians, nurses, scientists, and other experts as well as evidence-

based research to draw conclusions and formulate its recommendations. The Guidelines provide for an exemption for certain religious employers, which is modeled on an option available in some of the 28 states that already require coverage of contraception.<sup>[11]</sup> Additionally, the Administration announced that non-profit, religious employers who do not currently offer contraceptive coverage would not have to comply with the requirement for a year and new regulations would be developed and finalized by the end of the year to accommodate religious concerns while ensuring access to this benefit.

While the costs of contraceptives for individual women can be substantial and can influence choice of contraceptive methods,<sup>[12]</sup> available data indicate that providing contraceptive coverage as part of a health insurance benefit does not add to the cost of providing insurance coverage.

## Empirical Evidence on the Cost of Contraception

Evidence from well-documented prior expansions of contraceptive coverage indicates that the cost to issuers of including coverage for all FDA-approved contraceptive methods in insurance offered to an employed population is zero.

In 1999, Congress required the health plans in the Federal Employees Health Benefits (FEHB) program to cover the full range of FDA-approved contraceptive methods. The FEHB program is the largest employer-sponsored health benefits program in the United States, and at the time, it covered approximately 9 million Federal Employees, retirees and their family members and included approximately 300 health plans. The premiums for 1999 had already been set when the legislation passed, so the Office of Personnel Management (OPM), which administers the FEHB program, provided for a reconciliation process. However, there was no need to adjust premium levels because there was no cost increase as a result of providing coverage of contraceptive services.<sup>[13]</sup>

Also in 1999, Hawaii prohibited employer group health plans from excluding contraceptive services or supplies from coverage, requiring them to include FDA-approved contraceptive drugs or devices to prevent unintended pregnancy.<sup>[14]</sup> A report on this experience by the Insurance Commissioner of Hawaii concludes that the mandate did not appear to increase insurance costs in any of the four surveyed health plans in Hawaii servicing employer groups.<sup>[15]</sup>

## Review of Actuarial Studies

The direct costs of providing contraception as part of a health insurance plan are very low and do not add more than approximately 0.5% to the premium costs per adult enrollee.<sup>[16]</sup> Studies from three actuarial firms, Buck Consultants, PriceWaterhouseCoopers (PwC), and the Actuarial Research Corporation (ARC) have estimated the direct costs of providing contraception coverage. In 1998, Buck Consultants estimated that the direct cost of providing contraceptive benefits averaged \$21 per enrollee per year.<sup>[17]</sup> PwC actuaries completed an analysis using more recent, 2003 data from MedStat for the National Business Group on Health, and determined that a broader range of services (contraceptive services, plus lab and counseling services) would cost approximately \$41 per year.<sup>[18]</sup> The most recent actuarial analysis, completed by the Actuarial Research Corporation in July 2011, using data from 2010, estimated a cost of about \$26 per year per enrolled female.<sup>[19]</sup>

However, as indicated by the empirical evidence described above, these direct estimated costs overstate the total premium cost of providing contraceptive coverage. When medical costs associated with unintended pregnancies are taken into account, including costs of prenatal care, pregnancy complications, and deliveries, the net effect on premiums is close to zero.<sup>[10], [11]</sup> One study author concluded, "The message is simple: regardless of payment mechanism or contraceptive method, contraception saves money."<sup>[12]</sup>

When indirect costs such as time away from work and productivity loss are considered, they further reduce the total cost to an employer. Global Health Outcomes developed a model that incorporates costs of contraception, costs of unintended pregnancy, and indirect costs. They find that it saves employers \$97 per year per employee to offer a comprehensive contraceptive benefit.<sup>[13]</sup> Similarly, the PwC actuaries state that after all effects are taken into account, providing contraceptive services is □cost-saving.□<sup>[14]</sup>

## Public Programs

Providing contraception through public programs is also cost-saving. Each year, public funding for family planning prevents about 1.94 million unintended pregnancies, including almost 400,000 teen pregnancies. Preventing these pregnancies results in 860,000 fewer unintended births, 810,000 fewer abortions and 270,000 fewer miscarriages. More than nine in 10 women receiving publicly-funded family planning services would be eligible for Medicaid-funded prenatal, delivery, and postpartum care services upon pregnancy. Avoiding the significant costs associated with these unintended births saves taxpayers \$4 for every \$1 spent on family planning.<sup>[15]</sup>

During the 1990s, many states implemented Medicaid Section 1115 Family Planning Demonstrations. An independent evaluation of the experience of six of these states found that all six Demonstrations yielded savings, with annual state savings ranging between \$1.3 million in New Mexico and nearly \$30 million in Arkansas.<sup>[16]</sup> As of August 1, 2010, 27 states, including States like Pennsylvania, Texas, Florida, and Virginia had expanded Medicaid eligibility for family planning services under waivers that stipulated that these expansions be budget neutral. Based on this experience, the Congressional Budget Office has estimated that expanding family planning to all States would save \$400 million over 10 years.<sup>[17]</sup>

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## Endnotes

<sup>[1]</sup> The Guidelines were published alongside an amendment to the July 2010 Preventive Services Rules that required non-grandfathered health plans to cover certain recommended preventive services without cost-sharing. The amendment to the July 2010 preventive services regulation exempts health plans sponsored or offered by certain religious employers from the requirement to cover contraceptive services.

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THE KAISER FAMILY FOUNDATION  
- AND -  
HEALTH RESEARCH &  
EDUCATIONAL TRUST

# Employer Health Benefits

2010  
ANNUAL SURVEY



-and-



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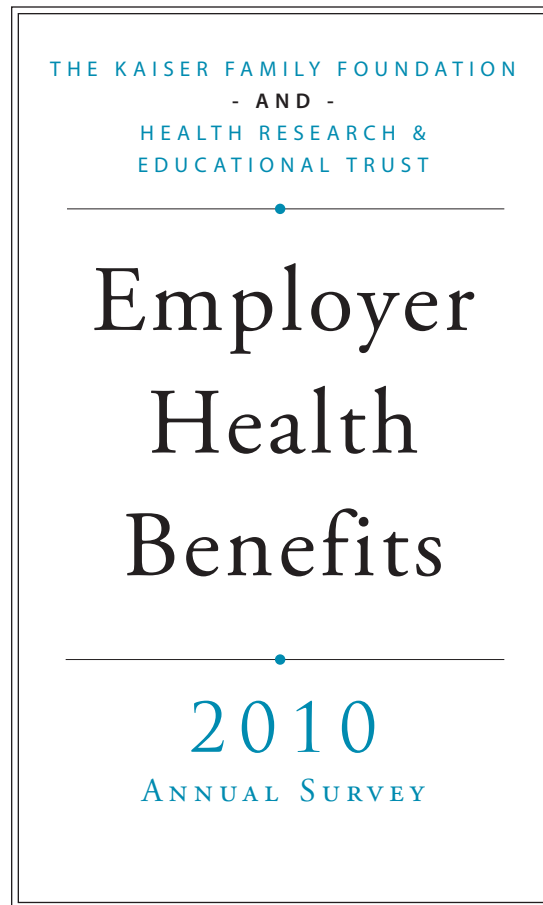
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## SUMMARY OF FINDINGS

EMPLOYER-SPONSORED INSURANCE IS THE LEADING SOURCE OF HEALTH INSURANCE, COVERING ABOUT 157 MILLION NONELDERLY PEOPLE IN AMERICA.<sup>1</sup> TO PROVIDE CURRENT INFORMATION ABOUT THE NATURE OF EMPLOYER-SPONSORED HEALTH BENEFITS, THE KAISER FAMILY FOUNDATION (KAISER) AND THE HEALTH RESEARCH & EDUCATIONAL TRUST (HRET) CONDUCT AN ANNUAL NATIONAL SURVEY OF NONFEDERAL PRIVATE AND PUBLIC EMPLOYERS WITH THREE OR MORE WORKERS. THIS IS THE TWELFTH KAISER/HRET SURVEY AND REFLECTS HEALTH BENEFIT INFORMATION FOR 2010.

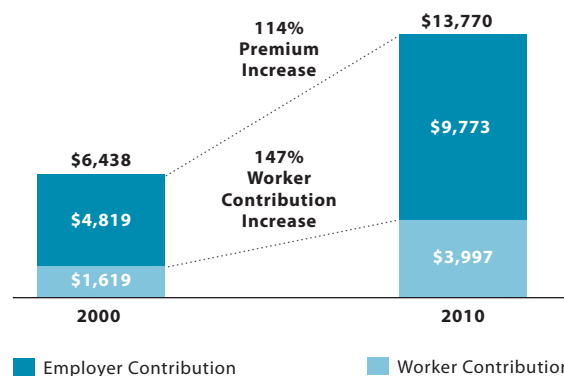
The key findings from the 2010 survey, conducted from January through May 2010, include increases in the average single and family premium as well as in the amount workers pay for coverage. About a quarter (27%) of covered workers have a deductible of at least \$1,000 for single coverage, and a greater proportion of workers are enrolled in high-deductible health plans with a savings option (HDHP/SO) than in 2009. Firms responded that they increased cost sharing or reduced the scope of coverage, or increased the amount workers pay for insurance as a result of the economic downturn. The 2010 survey continues to track the percentage of firms offering wellness benefits or health risk assessments and also included questions on health plan quality indicators and benefit changes made as result of the Mental Health Parity and Addiction Equity Act.

## HEALTH INSURANCE PREMIUMS AND WORKER CONTRIBUTIONS

The average annual premiums for employer-sponsored health insurance in 2010 are \$5,049 for single coverage and \$13,770 for family coverage. Compared to 2009, premiums for single coverage are 5% higher (\$4,824) and premiums for family coverage are 3% higher (\$13,375). Since 2000, average premiums for family coverage have increased 114% (Exhibit A). Average premiums for family coverage are lower for workers in small firms (3–199 workers) than for workers in large firms (200 or more workers) (\$13,250 vs. \$14,038). Average premiums for high-deductible health plans with a savings option (HDHP/SOs) are lower than the overall average for all plan types for both single and family coverage (Exhibit B). For PPOs, the most common plan type, the average family premium topped \$14,000 annually in 2010.

### EXHIBIT A

**Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2000–2010**



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000–2010.

As a result of factors such as benefit differences and geographical cost differences, there is significant variation around the average annual premium.

Twenty percent of covered workers are in plans with an annual total premium for family coverage of at least \$16,524 (120% of the average premium), while 19% of covered workers are in plans where the family premium is less than \$11,016 (80% of the average premium) (Exhibit C).

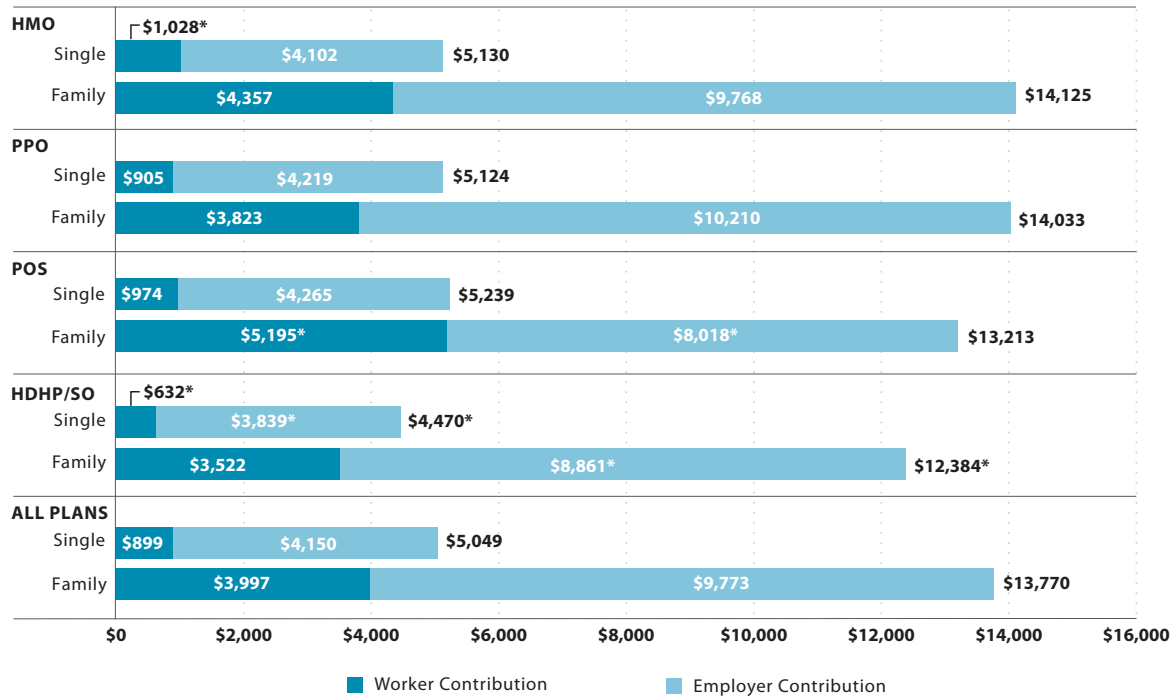
In 2010, covered workers contributed a greater share of the total premium, a notable change from the steady share workers have paid on average over the last decade. Covered workers on average contribute 19% of the total premium for single coverage (up from 17% in 2009) and 30% for family coverage (up from 27% in 2009). As with total premiums, the premium shares contributed by workers vary considerably around these averages. For single coverage, 28% of workers pay more than 25% of the total premium while 16% make no contribution.

Fifty-one percent of workers with family coverage pay more than 25% of the total premium; only 5% make no contribution (Exhibit D).

Looking at dollar amounts, the average annual worker contributions are \$899 for single coverage and \$3,997 for family coverage, up from \$779 and \$3,515 respectively in 2009.<sup>2</sup> Workers in small firms (3–199 workers) contribute about the same amount for single coverage as workers in large firms (200 or more workers) (\$865 vs. \$917), but they contribute significantly more for family coverage (\$4,665 vs. \$3,652).

## PLAN ENROLLMENT

The majority (58%) of covered workers are enrolled in preferred provider organizations (PPOs), followed by health maintenance organizations (HMOs) (19%), HDHP/SOs (13%), point-of-service (POS) plans (8%), and conventional plans (1%). Most notably, the percentage of covered workers in HDHP/SOs rose from 8% in 2009 to 13% in 2010.

**EXHIBIT B****Average Annual Employer and Worker Premium Contributions and Total Premiums for Covered Workers for Single and Family Coverage, by Plan Type, 2010**

\* Estimate is statistically different from All Plans estimate by coverage type ( $p < .05$ ).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

**EMPLOYEE COST SHARING**

Most covered workers face additional costs when they use health care services. Most workers in PPOs (77%) and POS plans (66%) have a general annual deductible for single coverage that must be met before all or most services are payable by the plan. In contrast, only 28% of workers in HMOs have a general annual deductible for single coverage, although it is up from 16% in 2009. Many workers with no deductible have other forms of cost sharing for office visits or other services.

Among workers with a deductible, the average general annual deductible for single coverage is \$675 for workers in PPOs, \$601 for workers in HMOs, \$1,048 for workers in POS plans, and \$1,903 for workers in HDHP/SOs (which by definition have high deductibles). As in recent years, workers in small firms (3–199 workers) with single

coverage have higher deductibles than workers in large firms (200 or more workers). Average deductibles for single coverage do not vary by region for any plan type. The percentage of covered workers in a plan with a deductible of at least \$1,000 for single coverage grew from 22% to 27% in the past year. Covered workers in small firms remain more likely than covered workers in larger firms (46% vs. 17%) to be in plans with deductibles of at least \$1,000 (Exhibit E).

Most plans cover certain services before the deductible is met. For example, in the most common plan type, PPOs, 91% of covered workers with a general annual deductible do not have to meet the deductible before preventive care is covered. Seventy percent of covered workers in PPOs do not have to meet the deductible before physician office visits are covered, and 92% do not have to meet the deductible before prescription drugs are covered.

The majority of workers also have to pay a portion of the cost of physician office visits. For example, 75% of covered workers pay a copayment (a fixed dollar amount) and 16% pay coinsurance (a percentage of the charge) for a primary care office visit, and for specialty care visits, 73% of covered workers pay a copayment and 17% pay coinsurance. Most covered workers in HMOs, PPOs, and POS plans face copayments, while covered workers in HDHP/SOs are more likely to have coinsurance requirements or no cost sharing after the deductible is met. Covered workers with a copayment pay an average of \$22 for primary care and \$31 for specialty physicians for in-network office visits, compared to \$20 and \$28 respectively for 2009. For covered workers with coinsurance, the average coinsurance is 18% both for primary care and specialty care. The survey collects information on in-network cost sharing, but we note that out-of-network cost sharing is often higher.

**EXHIBIT C****Distribution of Premiums for Single and Family Coverage Relative to the Average Annual Single or Family Premium, 2010**

Premium Range, Relative to Average Premium	Single Coverage		Family Coverage	
	Premium Range, Dollar Amount	Percentage of Covered Workers in Range	Premium Range, Dollar Amount	Percentage of Covered Workers in Range
Less than 80%	Less than \$4,039	20%	Less Than \$11,016	19%
80% to Less Than 90%	\$4,039 to <\$4,544	16%	\$11,016 to <\$12,393	18%
90% to Less Than Average	\$4,544 to <\$5,049	21%	\$12,393 to <\$13,770	14%
Average to Less Than 110%	\$5,049 to <\$5,554	16%	\$13,770 to <\$15,147	18%
110% to Less Than 120%	\$5,554 to <\$6,058	10%	\$15,147 to <\$16,524	12%
120% or More	\$6,058 or More	17%	\$16,524 or More	20%

Note: The average premium is \$5,049 for single coverage and \$13,770 for family coverage.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

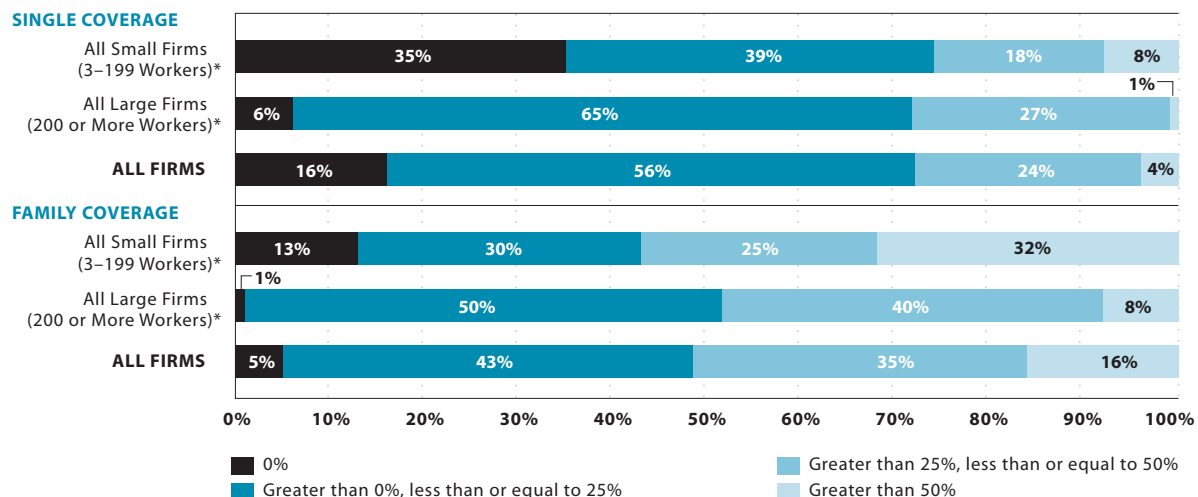
Almost all covered workers (99%) have prescription drug coverage, and the majority face cost sharing for their prescriptions. Over three-quarters (78%) of covered workers are in plans with three or more levels or tiers of cost sharing that are generally based on the type or cost of the drug. Copayments are more common than coinsurance for all four tiers. Among workers with three- or four-tier plans,

the average copayments per prescription are \$11 for first-tier drugs, often called generics; \$28 for second-tier drugs, often called preferred; \$49 for third-tier drugs, often called nonpreferred; and \$89 for fourth-tier drugs.

Cost sharing for prescription drugs varies by plan type. Covered workers in HDHP/SOs are more likely than workers in other plan

types to be in plans with no cost sharing after the deductible is met or in plans where the cost sharing is the same regardless of the type of drug.

Most workers also face additional cost sharing for a hospital admission or an outpatient surgery. For hospital admissions, after any general annual deductible, 53% of covered workers have coinsurance,

**EXHIBIT D****Distribution of the Percentage of Total Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2010**

\* Distributions for All Small Firms and All Large Firms are statistically different ( $p < .05$ ).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

19% have a copayment, and 10% have both coinsurance and copayments. An additional 5% have a per day (per diem) payment and 5% have a separate annual hospital deductible. For hospital admissions, the average coinsurance rate is 18%, the average copayment is \$232 per hospital admission, the average per diem charge is \$228, and the average separate hospital deductible is \$723.

Although covered workers are often responsible for cost sharing when accessing health services, there is often a limit to the amount of cost sharing workers must pay each year, generally referred to as an out-of-pocket maximum. Eighty-two percent of covered workers have an out-of-pocket maximum for single coverage, but the limits vary considerably. For example, among covered workers in plans that have an out-of-pocket maximum for single coverage, 31% are in plans with an annual out-of-pocket maximum of \$3,000 or more, and 16% are in plans with an out-of-pocket maximum of less than \$1,500. Even where plans have out-of-pocket limits, not all spending may count toward the out-of-pocket maximum. For example, among workers in PPOs with an out-of-pocket maximum, 74% are in

plans that do not count physician office visit copayments, 32% are in plans that do not count spending for the general annual deductible, and 80% are in plans that do not count prescription drug spending when determining if an enrollee has reached the out-of-pocket limit.

Some health plans limit the amount that the plan will pay in benefits for an enrollee in a year. Twelve percent of covered workers are in plans with an annual limit on benefits for single coverage.

#### AVAILABILITY OF EMPLOYER-SPONSORED COVERAGE

Sixty-nine percent of firms reported offering health benefits, which is significantly higher than the 60% reported last year (Exhibit F). The change is largely the result of a 13 percentage point increase in offering among firms with 3 to 9 workers. While there has been some instability in this size category in the past, this year's change is much larger than previously observed, and the reason for such a change is unclear. Given the slow economic recovery and high unemployment, it seems unlikely that many firms began offering coverage.

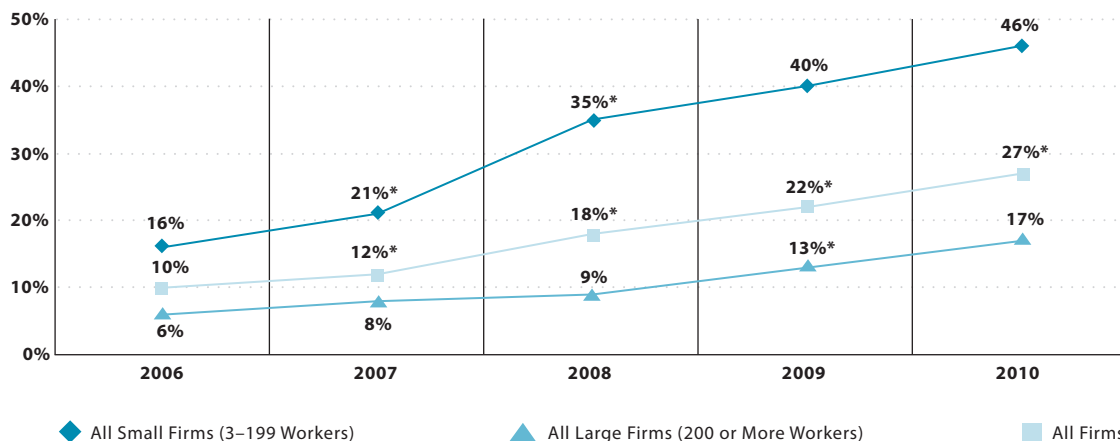
A possible explanation is that non-offering firms were more likely to fail during the past year, and the attrition of non-offering firms led to a higher offer rate among surviving firms.

The higher offer rate observed for the smallest firms did not produce a large change in the percentage of workers in firms offering benefits because most workers are employed by large firms. The percentage of workers in firms offering health benefits rose from 91% in 2009 to 93% in 2010.

Even in firms that offer coverage, not all workers are covered. Some workers are not eligible to enroll as a result of waiting periods or minimum work-hour rules. Others choose not to enroll, perhaps because of the cost of coverage or their ability to access coverage through a spouse. Among firms that offer coverage, an average of 79% of workers are eligible for the health benefits offered by their employer. Of those eligible, 80% take up coverage, resulting in 63% of workers in firms offering health benefits having coverage through their employer. Among both firms that offer and do not offer health benefits, 59% of workers are covered by health plans offered by their employer, the same percentage as reported last year.

#### EXHIBIT E

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of \$1,000 or More for Single Coverage, by Firm Size, 2006–2010



\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

Note: These estimates include workers enrolled in HDHP/SO and other plan types. Because we do not collect information on the attributes of conventional plans, to be conservative, we assumed that workers in conventional plans do not have a deductible of \$1,000 or more. Because of the low enrollment in conventional plans, the impact of this assumption is minimal.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006–2010.

## HIGH-DEDUCTIBLE HEALTH PLANS WITH SAVINGS OPTION

High-deductible health plans with a savings option include (1) health plans with a deductible of at least \$1,000 for single coverage and \$2,000 for family coverage offered with an Health Reimbursement Arrangement (HRA), referred to as “HDHP/HRAs,” and (2) high-deductible health plans that meet the federal legal requirements to permit an enrollee to establish and contribute to a Health Savings Account (HSA), referred to as “HSA-qualified HDHPs.”

Fifteen percent of firms offering health benefits offer an HDHP/SO in 2010. Among firms with 1,000 or more workers, 34% offer an HDHP/SO, up from 28% in 2009 and 22% in 2008.

Thirteen percent of covered workers are enrolled in HDHP/SOs, up from 8% in 2009. Seven percent of covered workers are enrolled in HDHP/HRAs, up from 3% in 2009. The percentage of covered workers enrolled in HSA-qualified HDHPs remained steady at 6%. Nine

percent of covered workers in small firms (3–199 workers) are enrolled in HSA-qualified HDHPs, compared to 5% of workers in large firms (200 or more workers) (Exhibit G).

Annual deductibles for single coverage for HDHP/HRAs and HSA-qualified HDHPs average \$1,737 and \$2,096, respectively, similar to last year. Workers in HSA-qualified HDHPs in small firms (3–199 workers) face higher deductibles for single coverage (\$2,284) and family

## EXHIBIT F

Percentage of Firms Offering Health Benefits, by Firm Size, 1999–2010

FIRM SIZE	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
3–9 Workers	56%	57%	58%	58%	55%	52%	47%	48%	45%	49%	46%	59%*
10–24 Workers	74	80	77	70*	76	74	72	73	76	78	72	76
25–49 Workers	86	91	90	86	84	87	87	87	83	90*	87	92
50–199 Workers	97	97	96	95	95	92	93	92	94	94	95	95
<b>All Small Firms (3–199 Workers)</b>	<b>65%</b>	<b>68%</b>	<b>68%</b>	<b>66%</b>	<b>65%</b>	<b>63%</b>	<b>59%</b>	<b>60%</b>	<b>59%</b>	<b>62%</b>	<b>59%</b>	<b>68%*</b>
<b>All Large Firms (200 or More Workers)</b>	<b>99%</b>	<b>99%</b>	<b>99%</b>	<b>98%</b>	<b>98%</b>	<b>99%</b>	<b>98%</b>	<b>98%</b>	<b>99%</b>	<b>99%</b>	<b>98%</b>	<b>99%</b>
<b>ALL FIRMS</b>	<b>66%</b>	<b>69%</b>	<b>68%</b>	<b>66%</b>	<b>66%</b>	<b>63%</b>	<b>60%</b>	<b>61%</b>	<b>60%</b>	<b>63%</b>	<b>60%</b>	<b>69%*</b>

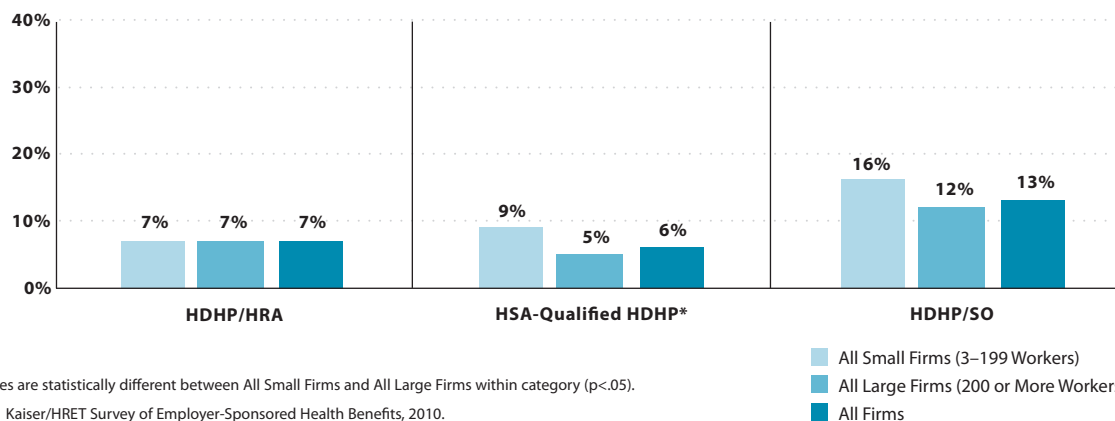
\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

Note: As noted in the Survey Design and Methods section, estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

## EXHIBIT G

Percentage of Covered Workers Enrolled in an HDHP/HRA or HSA-Qualified HDHP, by Firm Size, 2010



coverage (\$4,258) than workers with HSA-qualified HDHPs in large firms (200 or more workers), where deductibles average \$1,895 for single coverage and \$3,734 for an aggregate deductible for family coverage.<sup>3</sup> Like workers in other plan types, workers in small firms covered by an HDHP/HRA face higher deductibles than workers in large firms with these plans for single coverage (\$2,119 vs. \$1,541).<sup>4</sup>

The distinguishing aspect of these high-deductible plans is the savings feature available to employees. Workers enrolled in an HDHP/HRA receive an average annual contribution from their employer of \$907 for single coverage and \$1,619 for family coverage (Exhibit H). The average HSA contribution is \$558 for single coverage and \$1,006 for family coverage. Not all firms contribute to the HSA. About two in five firms offering these plans (covering about 65% of workers covered by HSA-qualified HDHPs) make contributions to the HSAs

of their workers. The average employer contributions to HSAs in these contributing firms are \$858 for single coverage and \$1,546 for family coverage.

The average premiums for single coverage for workers in HSA-qualified HDHPs and HDHP/HRAs are lower than the average premiums for workers in plans that are not HDHP/SOs. For family coverage, the average premium for HSA-qualified HDHPs is lower than the average family premium for workers in plans that are not HDHP/SOs. The average worker contributions to HSA-qualified HDHP single coverage are also lower than the average for non-HDHP/SO plans.

### RETIREE COVERAGE

Twenty-eight percent of large firms (200 or more workers) offer retiree health benefits in 2010, which is not statistically different from the 2009 offer rate of 30%, but down from 34% in 2005.<sup>5</sup> Only a

small percentage (3%) of small firms (3–199 workers) offer retiree health benefits. Among large firms that offer retiree health benefits, 93% offer health benefits to early retirees (retiring before age 65) and 75% offer health benefits to Medicare-age retirees.

### WELLNESS BENEFITS AND DISEASE MANAGEMENT

Workplace wellness programs are seen by some to be an important tool for improving the health behaviors and health of workers and their families. Almost three-fourths (74%) of employers that offer health benefits offer at least one of the following wellness programs: weight loss program, gym membership discounts or on-site exercise facilities, smoking cessation program, personal health coaching, classes in nutrition or healthy living, web-based resources for healthy living, or a wellness newsletter. The percentage of firms offering wellness benefits increased in the past

## EXHIBIT H

### Average Annual Premiums and Contributions to Savings Accounts for Covered Workers in HDHP/HRAs or HSA-Qualified HDHPs, Compared to All Non-HDHP/SO Plans, 2010

	HDHP/HRA		HSA-Qualified HDHP		Non-HDHP/SO Plans <sup>§</sup>	
	Single	Family	Single	Family	Single	Family
<b>Total Annual Premium</b>	\$4,702*	\$13,068	\$4,233*	\$11,683*	\$5,136	\$13,979
Worker Contribution to Premium	\$799	\$3,604	\$444*	\$3,457	\$939	\$4,069
Firm Contribution to Premium	\$3,903	\$9,464	\$3,789*	\$8,225*	\$4,197	\$9,910
<b>Annual Firm Contribution to the HRA or HSA<sup>‡</sup></b>	\$907	\$1,619	\$558	\$1,006	NA	NA
<b>Total Annual Firm Contribution</b> (Firm Share of Premium Plus Firm Contribution to HRA or HSA)	\$4,810*	\$11,083*	\$4,347	\$9,231	\$4,197	\$9,910
<b>Total Annual Cost</b> (Total Premium Plus Firm Contribution to HRA or HSA, if Applicable)	\$5,608*	\$14,687	\$4,791*	\$12,688*	\$5,136	\$13,979

\* Estimate is statistically different from estimate for All Non-HDHP/SO Plans ( $p < .05$ ).

<sup>‡</sup> When those firms that do not contribute to the HSA (60% for single coverage and 61% for family coverage) are excluded from the calculation, the average firm contribution to the HSA for covered workers is \$858 for single coverage and \$1,546 for family coverage. For HDHP/HRAs, we refer to the amount that the employer commits to make available to an HRA as a contribution for ease of discussion. HRAs are notional accounts, and employers are not required to actually transfer funds until an employee incurs expenses. Thus, employers may not expend the entire amount that they commit to make available to their employees through an HRA. Therefore, the employer contribution amounts to HRAs that we capture in the survey may exceed the amount that employers will actually spend.

<sup>§</sup> In order to compare costs for HDHP/SOs to all other plans that are not HDHP/SOs, we created composite variables excluding HDHP/SO data.

NA: Not Applicable.

Note: Values shown in the table may not equal the sum of their component parts. The averages presented in the table are aggregated at the firm level and then averaged, which is methodologically more appropriate than adding the averages. This is relevant for Total Annual Premium, Total Annual Firm Contribution, and Total Annual Cost.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

year (from 58% in 2009), however the increase was primarily the result of a higher percentage of firms (51%) reporting the availability of web-based resources for healthy living in 2010 than in 2009 (36%). Firms offering health coverage and wellness benefits report that most wellness benefits (87%) are provided through the health plan rather than by the firm directly. Only a small percentage of firms (10%) offering health benefits and one of the specified wellness programs offer incentives for workers to participate in the wellness program.

Health risk assessments provide a way for employers and plans to identify potential health risks and needs of covered workers. Eleven percent of firms offering health benefits give their employees the option of completing a health risk assessment, and over one-half (53%) of these firms use health risk assessments as a method to identify people for participation in a wellness program.<sup>6</sup> Large firms (200 or more workers) are more likely to offer a health risk assessment to employees than small firms (3–199 workers) (55% vs. 10%). Twenty-two percent of firms offering health risk assessments offer financial incentives for workers to complete them. Large firms are more likely than small firms to offer financial incentives (36% vs. 19%). Among firms that reported offering financial incentives to employees that complete a health risk assessment,

39% of firms reported that they offer gift cards, travel, merchandise, or cash;<sup>7</sup> 14% of firms reported that employees pay a smaller share of the premium; 8% reported employees have a smaller deductible; and 1% reported employees have a lower coinsurance rate.

Thirty-one percent of firms offering health benefits reported that their largest plan includes one or more disease management programs, similar to the 26% reported in 2008 when the question was last asked. Large firms (200 or more workers) are more likely than small firms (3–199 workers) to include a disease management program in their largest plan (67% vs. 30%).

## OTHER TOPICS

**Health Plan Quality.** In 2010, we asked firms whether they review performance indicators on health plans' clinical and service quality. Large firms (200 or more workers) were more likely to review performance indicators than small firms (3–199 workers) (34% vs. 5%). Among those who reported reviewing performance indicators, the most common indicators used were the Consumer Assessment of Healthcare Providers and Systems (CAHPS) (77%) and hospital outcomes data (61%). Seventy-four percent reported that they were "somewhat satisfied" or "very satisfied" with the information

available on health plan quality. However, only 49% reported that the information was "somewhat influential" or "very influential" in their decision to select health plans.

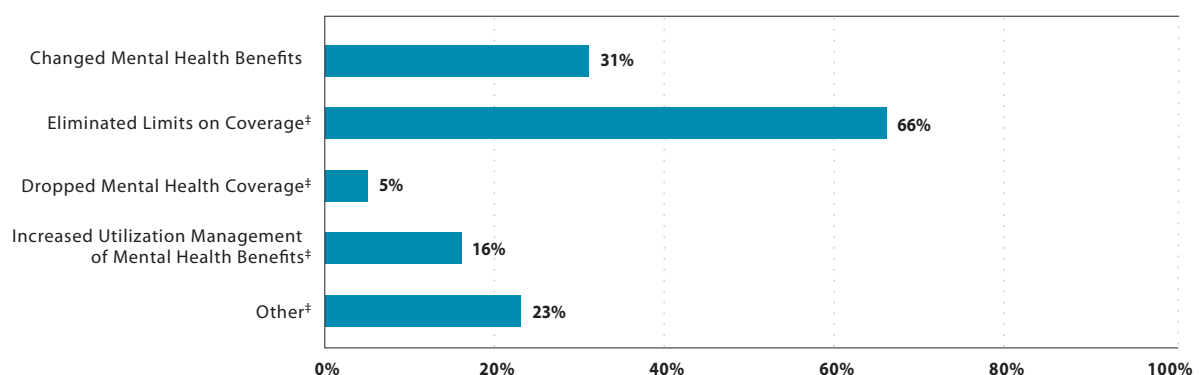
### Response to the Economic Downturn.

For the last two years we have asked employers about changes that they made to their health benefits in response to the poor economy. This year, 30% of employers responded that they reduced the scope of health benefits or increased cost sharing, and 23% said that they increased the share of the premium a worker has to pay. Among large firms (200 or more workers), 38% reported reducing the scope of benefits or increasing cost sharing, up from 22% in 2009, while 36% reported increasing their workers' premium share, up from 22% in 2009.

**Mental Health Parity.** The enactment of the Mental Health Parity and Addiction Equity Act in 2008 led firms with more than 50 workers to make changes in their mental health benefits.<sup>8</sup> Thirty-one percent of firms with more than 50 workers responded that they had made changes; large firms (200 or more workers) were more likely to have done so than small firms (51–199 workers) (43% vs. 26%). Among firms that changed their benefits, two-thirds (66%) eliminated limits on coverage, 16% increased utilization management for mental health benefits, and 5% indicated they dropped mental health coverage (Exhibit I).

## EXHIBIT I

Percentage of Firms With More Than 50 Workers Reporting the Following as a Result of the 2008 Mental Health Parity and Addiction Equity Act, 2010



<sup>‡</sup> Among firms reporting they made changes to the mental health benefits they offer as a result of the Mental Health Parity and Addiction Equity Act of 2008.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

## CONCLUSION

The 2010 survey finds a continuation of the modest premium growth we have seen in recent years and higher out-of-pocket costs for employees. Premiums increased just 5% for single coverage and 3% for family coverage between 2009 and 2010. At the same time, workers saw their share of the premiums for single and family coverage

grow for the first time in several years.

The percentage of workers in plans with a deductible of at least \$1,000 for single coverage continues to climb, with over a quarter (27%) of workers in large firms and almost one-half (46%) of workers in small firms in such plans. The percentage of workers in HDHP/SOs rose significantly from 8% to 13% over the last year.

Tracking whether and how worker out-of-pocket costs continue to grow will be an important focus for the survey over the next few years. The slow economic recovery and continuing high unemployment suggests that this trend of increasing out-of-pocket costs will persist, as workers have little clout to demand better benefits or lower costs in the current labor environment.

<sup>1</sup> Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer*, October 2009.

<sup>2</sup> The average worker contributions include those workers with no contribution.

<sup>3</sup> Data presented are for workers with a family aggregate deductible where spending by any covered person in the family counts toward the deductible.

<sup>4</sup> There are insufficient data for average HDHP/HRA aggregate deductibles in small firms to make the comparison for family coverage.

<sup>5</sup> We now count the 0.46% of large firms that indicate they offer retiree coverage but have no retirees as offering retiree health benefits. Historical numbers have been recalculated so that the results are comparable.

<sup>6</sup> Health risk assessments generally include questions on medical history, health status, and lifestyle.

<sup>7</sup> In 2010, we ask only those firms that offer financial incentives to employees who complete a health risk assessment if they provide gift cards, travel, merchandise, or cash, whereas in 2009, this question was asked of all firms offering health risk assessments, including those who responded that they did not offer financial incentives.

<sup>8</sup> For more information on the Mental Health Parity and Addiction Equity Act of 2008, see [www.cms.gov/healthinsreformforconsume/04\\_thementalhealthparityact.asp](http://www.cms.gov/healthinsreformforconsume/04_thementalhealthparityact.asp).

EMPLOYER HEALTH BENEFITS  
2010 ANNUAL SURVEY

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Survey  
Design  
and  
Methods

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## SURVEY DESIGN AND METHODS

THE KAISER FAMILY FOUNDATION AND THE HEALTH RESEARCH & EDUCATIONAL TRUST (KAISER/HRET) CONDUCT THIS ANNUAL SURVEY OF EMPLOYER-SPONSORED HEALTH BENEFITS. HRET, A NONPROFIT RESEARCH ORGANIZATION, IS AN AFFILIATE OF THE AMERICAN HOSPITAL ASSOCIATION. THE KAISER FAMILY FOUNDATION DESIGNS, ANALYZES, AND CONDUCTS THIS SURVEY IN PARTNERSHIP WITH HRET, AND ALSO PAYS FOR THE COST OF THE SURVEY. HRET SUBCONTRACTS WITH RESEARCHERS AT NATIONAL OPINION RESEARCH CENTER (NORC) AT THE UNIVERSITY OF CHICAGO, WHO WORK WITH FOUNDATION AND HRET RESEARCHERS IN CONDUCTING THE STUDY. KAISER/HRET RETAINED NATIONAL RESEARCH, LLC (NR), A WASHINGTON, D.C.-BASED SURVEY RESEARCH FIRM, TO CONDUCT TELEPHONE INTERVIEWS WITH HUMAN RESOURCE AND BENEFITS MANAGERS USING THE KAISER/HRET SURVEY INSTRUMENT. FROM JANUARY TO MAY 2010 NR COMPLETED FULL INTERVIEWS WITH 2,046 FIRMS.

### SURVEY TOPICS

As in past years, Kaiser/HRET asked each participating firm as many as 400 questions about its largest health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) plan, and high-deductible health plan with a savings option (HDHP/SO).<sup>1</sup> In 2006, Kaiser/HRET began asking employers if they had a health plan that was an exclusive provider organization (EPO). We treat EPOs and HMOs together as one plan type and report the information under the banner of “HMO;” if an employer sponsors both an HMO and an EPO, they are asked about the attributes of the plan with the larger enrollment.

New topics in the 2010 survey include questions on eligibility for dependent coverage, coverage for care received at retail clinics, health plan changes as a result of the Mental Health Parity and Addiction Equity Act of 2008, and disease management. As in past years, this year’s survey included questions on the cost of health insurance, offer rates, coverage, eligibility, enrollment patterns, premiums,<sup>2</sup> employee cost sharing, prescription drug benefits, retiree health benefits, wellness benefits, and employer opinions.

### RESPONSE RATE

After determining the required sample from U.S. Census Bureau data, Kaiser/HRET drew its sample from a Survey Sampling Incorporated list (based on an original Dun and Bradstreet list) of the nation’s private employers and from the Census Bureau’s Census of Governments list of public employers with three or more workers. To increase precision, Kaiser/HRET stratified the sample by industry and the number of workers in the firm. Kaiser/HRET attempted to repeat interviews with prior years’ survey respondents (with at least ten employees) who also participated in either the 2008 or the 2009 survey, or both. As a result, 1,547 firms in this year’s total sample of 2,046 firms participated in either the 2008, 2009, or both surveys.<sup>3</sup> The overall response rate is 47%.

The vast majority of questions are asked only of firms that offer health benefits. A total of 1,892 responding firms indicated that they offered health benefits. The overall response rate of firms that offer health benefits is 48%.

We asked one question of all firms in the study with which we made phone contact where the firm declined

#### NOTE:

<sup>1</sup> HDHP/SO includes high-deductible health plans offered with either a Health Reimbursement Arrangement (HRA) or a Health Savings Account (HSA). Although HRAs can be offered along with a health plan that is not an HDHP, the survey collected information only on HRAs that are offered along with HDHPs. For specific definitions of HDHPs, HRAs, and HSAs, see the introduction to Section 8.

<sup>2</sup> HDHP/SO premium estimates do not include contributions made by the employer to Health Savings Accounts or Health Reimbursement Arrangements.

<sup>3</sup> In total, 185 firms participated in 2007 and 2009, 367 firms participated in 2008 and 2009, and 939 firms participated in 2007, 2008, and 2009.

to participate. The question was, “Does your company offer a health insurance program as a benefit to any of your employees?” A total of 3,143 firms responded to this question (including 2,046 who responded to the full survey and 1,097 who responded to this one question). Their responses are included in our estimates of the percentage of firms offering health benefits.<sup>4</sup> The response rate for this question is 73%.

#### FIRM SIZE CATEGORIES AND KEY DEFINITIONS

Throughout the report, exhibits categorize data by size of firm, region, and industry. Firm size definitions are as follows: All Small, 3 to 199 workers; and All Large, 200 or more workers. Occasionally, firm size categories will be broken into smaller groups. The All Small group may be categorized by: 3 to 24 workers, and 25 to 199 workers; or 3 to 9 workers, 10 to 24 workers, 25 to 49 workers, and 50 to 199 workers. The All Large group may be categorized by: 200 to 999 workers, 1,000 to 4,999 workers, and 5,000 or more workers. Exhibit M.1 shows selected characteristics of the survey sample. Exhibit M.3 identifies which states are in each region.

Exhibit M.2 displays the distribution of the nation’s firms, workers, and covered workers (employees receiving coverage from their employer). Among the over three million firms nationally, approximately 59.6% are firms employing 3 to 9 workers; such firms employ 8.3% of workers and 5.5% of workers covered by health insurance. In contrast, one percent of firms are firms employing 1,000 or more workers; these firms employ 47.5% of workers and 51.3% of covered workers. Therefore, the smallest firms dominate any national statistics about what employers in general are doing. In contrast, firms with 1,000 or more workers are the most important employer group in calculating statistics regarding covered workers, since they employ the largest percentage of the nation’s workforce.

Throughout this report, we use the term “in-network” to refer to services received from a preferred provider. Family coverage is defined as health coverage for a family of four.

Each year, the survey asks firms for the percentage of their employees that earn less than a specified amount. This year, the income threshold remained at \$23,000 per year. This threshold is based on the 25th percentile of workers’ earnings as reported by the Bureau of Labor

Statistics using data from the National Compensation Survey (2008), the most current data available at the time of the survey design. The threshold was then adjusted to account for the change in workers’ earnings from 2008 to 2009, using the Bureau of Labor Statistics’ Employment Cost Index.

#### ROUNDING AND IMPUTATION

Some exhibits in the report do not sum to totals due to rounding effects. In a few cases, numbers from distribution exhibits may not add to equal numbers referenced in the text due to rounding effects. Although overall totals and totals for size and industry are statistically valid, some breakdowns may not be available due to limited sample sizes. Where the unweighted sample size is fewer than 30, exhibits include the notation “NSD” (Not Sufficient Data).

To control for item nonresponse bias, Kaiser/HRET imputes values that are missing for most variables in the survey. In general, less than 5% of observations are imputed for any given variable. All variables are imputed following a hotdeck approach. In 2010, there were four variables where the imputation rate exceeded 20% but was less than 30%. For these cases, the unimputed variable was compared with the imputed variable and there is no statistically significant difference. There are a few variables that Kaiser/HRET has decided should not be imputed; these are typically variables where “don’t know” is considered a valid response option (for example, firms’ opinions about effectiveness of various strategies to control health insurance costs).

#### SAMPLE DESIGN

We determined the sample requirements based on the universe of firms obtained from the U.S. Census. Prior to the 2009 survey, the sample requirements were based on the total counts provided by Survey Sampling Incorporated (SSI) (which obtains data from Dun and Bradstreet). Over the years, we have found the Dun and Bradstreet frequency counts to be volatile because of duplicate listings of firms, or firms that are no longer in business. These inaccuracies vary by firm size and industry. In 2003, we began using the more consistent and accurate counts provided by the Census Bureau’s Statistics of U.S. Businesses and the Census of Governments as the basis for post-stratification,

#### NOTE:

<sup>4</sup> Estimates presented in Exhibits 2.1, 2.2 and 2.3 are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

although the sample was still drawn from a Dun and Bradstreet list. In order to further address this concern at the time of sampling, we now also use Census data as the basis for the sample.

We also define Education as a separate sampling category, rather than as a subgroup of the Service category. Prior to 2009, Education firms were a disproportionately large share of Service firms. Education is controlled for during post-stratification, and adjusting the sampling frame to also control for Education allows for a more accurate representation of both Education and Service industries.

In past years, both private and government firms were sampled from the Dun and Bradstreet database. Beginning in 2009, Government firms were sampled in-house from the 2007 Census of Governments. This change was made to eliminate the overlap of state agencies that were frequently sampled from the Dun and Bradstreet database. The sample of private firms is screened for firms that are related to state/local governments, and if these firms are identified in the Census of Governments, they are reclassified as government firms and a private firm is randomly drawn to replace the reclassified firm.

Finally, the data used to determine the 2010 Employer Health Benefits sample frame include the U.S. Census' 2006 Statistics of U.S. Businesses and the 2007 Census of Governments. At the time of the sample design (December 2009), these data represented the most current information on the number of public and private firms nationwide with three or more workers. As in the past, the post-stratification is based on the most up-to-date Census data available (the 2007 update to the Census of U.S. Businesses was purchased during the survey field period) and the 2007 Census of Governments. The Census of Governments is conducted every five years, and this is the second year the data from the 2007 Census of Governments have been available for use.

#### WEIGHTING AND STATISTICAL SIGNIFICANCE

Because Kaiser/HRET selects firms randomly, it is possible through the use of statistical weights to extrapolate the results to national (as well as firm size, regional, and industry) averages. These weights allow Kaiser/HRET to present findings based on the number of workers covered by health plans, the number of total workers, and the number of firms. In general, findings in dollar amounts (such as premiums, worker contributions, and cost sharing) are weighted by covered workers. Other estimates, such as the offer

rate, are weighted by firms. Specific weights were created to analyze the HDHP/SO plans that are offered with an HRA or that are HSA-qualified. These weights represent the proportion of employees enrolled in each of these arrangements.

Calculation of the weights follows a common approach. First, the basic weight is determined, followed by a nonresponse adjustment. As part of this nonresponse adjustment, Kaiser/HRET conducted a small follow-up survey of with small employers that refused to participate in the full survey. The follow-up survey is conducted in order to address concern regarding self-selection bias among small firms. Firms in the sample with 3–49 workers that did not complete the full survey are contacted and asked (or re-asked in the case of firms that previously responded to only one question about offering benefits) whether or not the firm offers health benefits. As part of the process, we conduct a McNemar test to verify that the results of the follow-up survey are comparable to the results from the original survey. If the test indicates that the results are comparable, a nonresponse adjustment is applied to the weights used when calculating firm offer rates. This year, for the first time since we began conducting the follow-up survey, the test indicated that the results from those answering the one question about offering health benefits in the original survey and those answering the follow-up survey were different (statistically significant difference at the  $p < 0.05$  level between the two surveys), suggesting the results are not comparable. Therefore, we did not use the results of this follow-up survey to adjust the weights as we have in the past. In the past, the nonresponse adjustment lowered the offer rate for smaller firms by one to three percentage points, so not making the adjustment this year makes the offer rate look somewhat higher when making comparisons to prior years. For 2010, we saw a very large and unexpected increase in the offer rate (from 60 percent in 2009 to 69 percent in 2010) overall and particularly for firms with 3 to 9 workers (from 46 percent in 2009 to 59 percent in 2010). While not making the adjustment this year added to the size of the change, there would have been a large and difficult to explain change even if a nonresponse adjustment comparable to previous years had been made.

Next, we trimmed the weights in order to reduce the influence of weight outliers. First, we identified common groups of observations. Within each group, we identified the median and the interquartile range of the weights and calculated the trimming cut point as the median plus six times the interquartile range ( $M + [6 * IQR]$ ). Weight

values larger than this cut point are trimmed to the cut point. In all instances, less than one percent of the weight values were trimmed.

Finally, we applied a post-stratification adjustment. We used the U.S. Census Bureau's 2007 Statistics of U.S. Businesses as the basis for the stratification and the post-stratification adjustment for firms in the private sector, and we used the 2007 Census of Governments as the basis for post-stratification for public sector firms.

We continue to ask firms whether or not they offer a conventional health plan and, if so, how many of their covered workers are enrolled in that plan and whether it is self-funded or underwritten by an insurer. However, due to the declining market share of conventional health plans, in 2006, we stopped asking respondents additional questions about the attributes of the conventional plans they offer.<sup>5</sup> As of 2009 our primary covered worker weight no longer includes those workers with conventional coverage. Therefore, premium and cost-sharing levels are estimated among workers covered by an HMO, PPO, POS plan, or HDHP/SO. Removing workers covered by conventional health insurance from the covered worker weight has little impact on the estimates reported for "All Plans," such as the average single or family premium. In cases where a firm offers only conventional health plans, no information from that respondent is included in "All Plan" averages. The exception is for whether or not the plan is self-funded, for which we have information. For enrollment statistics, we weight the statistics by all covered workers, including those in conventional insurance.

The survey contains a few questions on employee cost sharing that are asked only of firms that indicate in a previous question that they have a certain cost-sharing provision. For example, the copayment amount for prescription drugs is asked only of those that report they have copayments for prescription drugs. Because the composite variables (using data from across all plan types) are reflective of only those plans with the provision, separate weights for the relevant variables were created in order to account for the fact that not all covered workers have such provisions.

The data are analyzed with SUDAAN,<sup>6</sup> which computes appropriate standard error estimates by controlling for the complex design of the survey.<sup>7</sup> All statistical tests are performed at the 0.05 level, unless otherwise noted. For figures with multiple years, statistical tests are conducted for each year against the previous year shown, unless otherwise noted. No statistical tests are conducted for years prior to 1999.

Statistical tests for a given subgroup (firms with 25–49 workers, for instance) are tested against all other firm sizes not included in that subgroup (all firm sizes NOT including firms with 25–49 workers, in this example). Tests are done similarly for region and industry; for example, Northeast is compared to all firms NOT in the Northeast (an aggregate of firms in the Midwest, South, and West). However, statistical tests for estimates compared across plan types (for example, average premiums in PPOs) are tested against the "All Plans" estimate. In some cases, we also test plan-specific estimates against similar estimates for other plan types (for example, single and family premiums for HDHP/SOs against single and family premiums for HMO, PPO, and POS plans); these are noted specifically in the text. The two types of statistical tests performed are the t-test and the Pearson Chi-square test.

The small number of observations for some variables, particularly variables specific to plans with Health Savings Accounts or Health Reimbursement Arrangements, resulted in large variability around the point estimates. These observations sometimes carry large weights, primarily for small firms. The reader should be cautioned that these influential weights may result in large movements in point estimates from year to year; however, often these movements are not statistically significant.

#### HISTORICAL DATA

Data in this report focus primarily on findings from surveys jointly authored by the Kaiser Family Foundation and the Health Research & Educational Trust, which have been conducted since 1999. Prior to 1999, the survey was conducted by the Health Insurance Association of America (HIAA) and KPMG using a similar survey instrument, but data are not

#### NOTE:

<sup>5</sup> In 2010, 1% of covered workers are enrolled in a conventional plan.

<sup>6</sup> Research Triangle Institute (2008). SUDAAN Software for the Statistical Analysis of Correlated Data, Release 10.0, Research Triangle Park, NC: Research Triangle Institute.

<sup>7</sup> A Technical Supplement with standard errors for select estimates for the 2010 Employer Health Benefits Survey can be found online at [www.kff.org/insurance/8085/index.cfm](http://www.kff.org/insurance/8085/index.cfm).

available for all the intervening years. Following the survey's introduction in 1987, the HIAA conducted the survey through 1990, but some data are not available for analysis. KPMG conducted the survey from 1991–1998. However, in 1991, 1992, 1994, and 1997, only larger firms were sampled. In 1993, 1995, 1996, and 1998, KPMG interviewed both large and small firms. In 1998, KPMG divested itself of its Compensation and Benefits Practice, and part of that divestiture included donating the annual survey of health benefits to HRET.

This report uses historical data from the 1993, 1996, and 1998 KPMG Surveys of Employer-Sponsored Health Benefits and the 1999–2009 Kaiser/HRET Survey of Employer-Sponsored Health Benefits. For a longer-term perspective, we also use the 1988 survey of the nation's employers conducted by the HIAA, on which the KPMG and Kaiser/HRET surveys are based. The survey designs for the three surveys are similar.

## EXHIBIT M.1

## Selected Characteristics of Firms in the Survey Sample, 2010

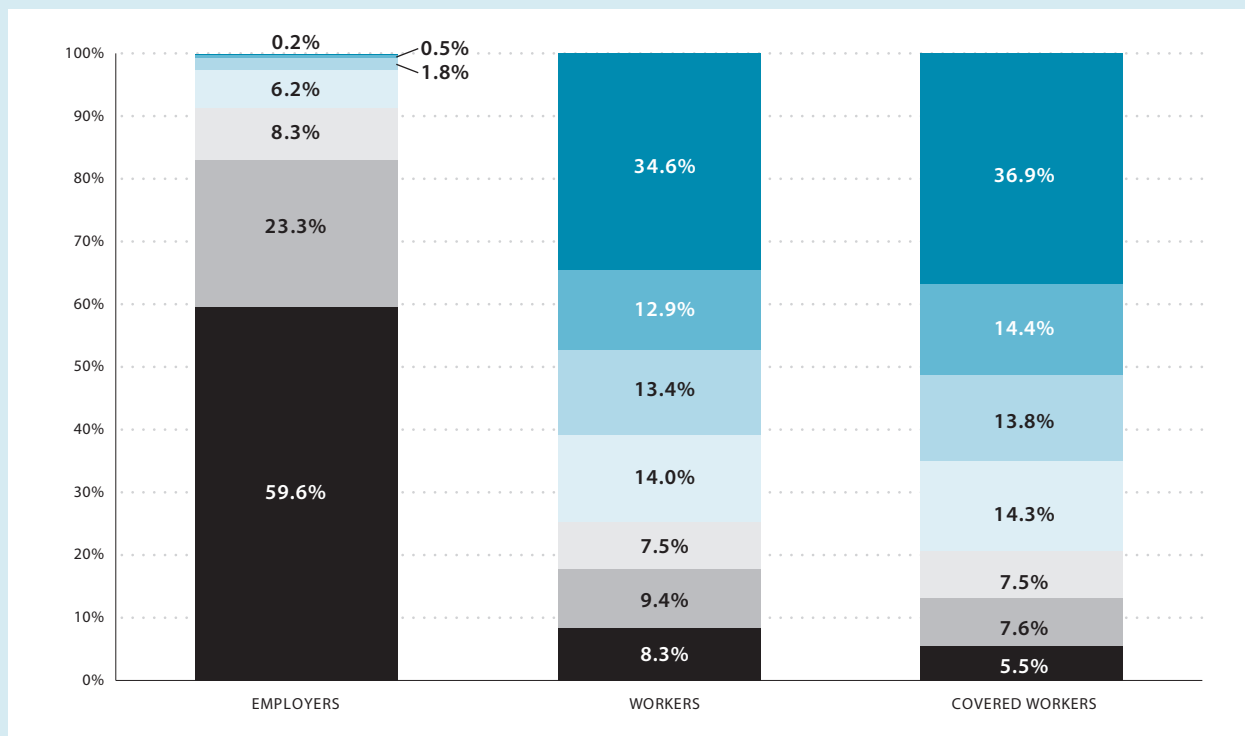
	Sample Size	Sample Distribution After Weighting	Percentage of Total for Weighted Sample
<b>FIRM SIZE</b>			
3–9 Workers	91	2,030,546	59.6%
10–24 Workers	211	795,120	23.3
25–49 Workers	170	282,541	8.3
50–199 Workers	300	211,879	6.2
200–999 Workers	470	60,925	1.8
1,000–4,999 Workers	483	17,545	0.5
5,000 or More Workers	321	8,242	0.2
<b>ALL FIRM SIZES</b>	<b>2,046</b>	<b>3,406,798</b>	<b>100%</b>
<b>REGION</b>			
Northeast	416	662,248	19.4%
Midwest	579	776,201	22.8
South	678	1,167,470	34.3
West	373	800,879	23.5
<b>ALL REGIONS</b>	<b>2,046</b>	<b>3,406,798</b>	<b>100%</b>
<b>INDUSTRY</b>			
Agriculture/Mining/Construction	126	421,087	12.4%
Manufacturing	201	209,101	6.1
Transportation/Communications/Utilities	121	128,114	3.8
Wholesale	105	193,150	5.7
Retail	142	423,924	12.4
Finance	130	234,153	6.9
Service	893	1,345,065	39.5
State/Local Government	138	50,587	1.5
Health Care	190	401,617	11.8
<b>ALL INDUSTRIES</b>	<b>2,046</b>	<b>3,406,798</b>	<b>100%</b>

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

## EXHIBIT M.2

## Distribution of Employers, Workers, and Workers Covered by Health Benefits, by Firm Size, 2010



## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

Note: Data are based on a special data request to the U.S. Census Bureau for their most recent (2007) Statistics of U.S. Businesses data on private sector firms. State and local government data are from the Census Bureau's 2007 Census of Governments.

5,000 OR MORE WORKERS  
 1,000-4,999 WORKERS  
 200-999 WORKERS  
 50-199 WORKERS  
 25-49 WORKERS  
 10-24 WORKERS  
 3-9 WORKERS

## EXHIBIT M.3

## States by Region, 2010

Northeast	Midwest	South	West
Connecticut	Illinois	Alabama	Alaska
Maine	Indiana	Arkansas	Arizona
Massachusetts	Iowa	Delaware	California
New Hampshire	Kansas	District of Columbia	Colorado
New Jersey	Michigan	Florida	Hawaii
New York	Minnesota	Georgia	Idaho
Pennsylvania	Missouri	Kentucky	Montana
Rhode Island	Nebraska	Louisiana	Nevada
Vermont	North Dakota	Maryland	New Mexico
	Ohio	Mississippi	Oregon
	South Dakota	North Carolina	Utah
	Wisconsin	Oklahoma	Washington
		South Carolina	Wyoming
		Tennessee	
		Texas	
		Virginia	
		West Virginia	

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010; U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau, available at [http://www.census.gov/geo/www/us\\_regdiv.pdf](http://www.census.gov/geo/www/us_regdiv.pdf).



EMPLOYER HEALTH BENEFITS  
2010 ANNUAL SURVEY

Cost of  
Health  
Insurance

SECTION

1

## COST OF HEALTH INSURANCE

THE AVERAGE ANNUAL PREMIUMS IN 2010 ARE \$5,049 FOR SINGLE COVERAGE AND \$13,770 FOR FAMILY COVERAGE. COMPARED TO 2009, THE AVERAGE PREMIUMS ARE ABOUT 5% AND 3% HIGHER FOR SINGLE AND FAMILY COVERAGE, RESPECTIVELY.

SMALLER FIRMS (3–199 WORKERS) HAVE A LOWER AVERAGE FAMILY PREMIUM (\$13,250) THAN LARGER FIRMS (200 OR MORE WORKERS) (\$14,038).

### PREMIUM COSTS FOR SINGLE AND FAMILY COVERAGE

- ▶ The average cost of premiums for single coverage in 2010 is \$421 per month or \$5,049 per year (Exhibit 1.1). The average cost of premiums for family coverage is \$1,147 per month or \$13,770 per year (Exhibit 1.1).
- ▶ The average premiums for covered workers in HDHP/SOs are lower for single and family coverage than the overall average premiums for covered workers (Exhibit 1.1).
- ▶ The average premium for family coverage for covered workers in small firms (3–199 workers) is lower than the average premium for workers in large firms (200 or more workers) (Exhibit 1.2). The average single premiums are similar for covered workers in small and large firms.
- ▶ Average single and family premiums for covered workers are higher in the Northeast and lower in the South than the average premiums for covered workers in other regions (Exhibit 1.3).
- ▶ Premiums also vary by plan funding and workforce attributes.
  - Average single and family premiums are higher for covered workers in firms with at least some union workers than for covered workers in firms with no union employees (Exhibit 1.5 and 1.6).
  - Covered workers in firms where 35% or more of workers are age 50 or older have higher average single and family premiums than covered workers in firms with a lower percentage of workers age 50 or older (Exhibits 1.5 and 1.6).
- Average single and family premiums are similar for covered workers in partially or fully self-funded plans or in fully insured plans (Exhibit 1.5 and 1.6). However, among large firms (200 or more workers), where most firms self fund their health benefits, workers in firms that are self-funded have lower single and family premiums than workers in firms that have insured benefits (Exhibits 1.5 and 1.6).
- ▶ There is a great deal of variation above and below the average premiums for both single and family coverage.
  - Seventeen percent of covered workers are employed by firms that have a single premium that is at least 20% higher than the average single premium of \$5,049, while 20% of covered workers are in firms that have a single premium that is less than 80% of the average single premium (Exhibit 1.7 and 1.8).
  - For family coverage, 20% of covered workers are employed in a firm that has a family premium that is at least 20% higher than the average family premium of \$13,770, while 19% of covered workers are in firms that have a family premium that is less than 80% of the average family premium (Exhibit 1.7 and 1.8).

### PREMIUM CHANGES OVER TIME

- ▶ In 2010, the average annual single premium (\$5,049) is 5% higher than the average premium in 2009 (\$4,824) and the family premium (\$13,770) is about 3% higher than the average annual family premium we reported last year (\$13,375) (Exhibit 1.11).
- The \$13,770 average annual family premium in 2010 is 27% higher than the average family premium in 2005 and 114% higher than the average family premium in 2000 (Exhibit 1.11).

- ▶ For the third year in a row, the average annual family premium for covered workers in small firms (3–199 workers) is significantly lower than the average annual family premium for covered workers in large firms (200 or more workers). The average annual family premiums for covered workers in small and large firms have been similar in most other earlier years (Exhibit 1.12).
- The average annual family premiums for covered workers in small and large firms have grown at similar rates between 2005 and 2010 (25% in small firms vs. 27% in large firms). Between 2000 and 2010, the average annual family premium for covered workers in small firms increased 103%, compared to an increase of 120% for workers in large firms (Exhibit 1.13).
- For large firms (200 or more workers), the average annual family premium for covered workers in firms that are fully insured has grown faster than for workers in fully or partially self-funded firms from 2005 to 2010 (35% in fully insured firms vs. 26% in self-funded firms) and from 2000 to 2010 (132% in fully insured firms vs. 116% in self-funded firms) (Exhibit 1.14).

## EXHIBIT 1.1

## Average Monthly and Annual Premiums for Covered Workers, Single and Family Coverage, by Plan Type, 2010

	Monthly	Annual
<b>HMO</b>		
Single Coverage	\$428	\$5,130
Family Coverage	\$1,177	\$14,125
<b>PPO</b>		
Single Coverage	\$427	\$5,124
Family Coverage	\$1,169	\$14,033
<b>POS</b>		
Single Coverage	\$437	\$5,239
Family Coverage	\$1,101	\$13,213
<b>HDHP/SO</b>		
Single Coverage	\$373*	\$4,470*
Family Coverage	\$1,032*	\$12,384*
<b>ALL PLAN TYPES</b>		
Single Coverage	\$421	\$5,049
Family Coverage	\$1,147	\$13,770

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different from All Plans estimate (p&lt;.05).

## EXHIBIT 1.2

## Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Firm Size, 2010

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
<b>HMO</b>				
All Small Firms (3–199 Workers)	\$428	\$1,107*	\$5,133	\$13,285*
All Large Firms (200 or More Workers)	427	1,208*	5,129	14,492*
<b>ALL FIRM SIZES</b>	<b>\$428</b>	<b>\$1,177</b>	<b>\$5,130</b>	<b>\$14,125</b>
<b>PPO</b>				
All Small Firms (3–199 Workers)	\$431	\$1,145	\$5,169	\$13,735
All Large Firms (200 or More Workers)	425	1,180	5,104	14,161
<b>ALL FIRM SIZES</b>	<b>\$427</b>	<b>\$1,169</b>	<b>\$5,124</b>	<b>\$14,033</b>
<b>POS</b>				
All Small Firms (3–199 Workers)	\$429	\$1,069	\$5,145	\$12,825
All Large Firms (200 or More Workers)	450	1,154	5,402	13,850
<b>ALL FIRM SIZES</b>	<b>\$437</b>	<b>\$1,101</b>	<b>\$5,239</b>	<b>\$13,213</b>
<b>HDHP/SO</b>				
All Small Firms (3–199 Workers)	\$371	\$1,002	\$4,454	\$12,022
All Large Firms (200 or More Workers)	373	1,053	4,482	12,640
<b>ALL FIRM SIZES</b>	<b>\$373</b>	<b>\$1,032</b>	<b>\$4,470</b>	<b>\$12,384</b>
<b>ALL PLANS</b>				
All Small Firms (3–199 Workers)	\$420	\$1,104*	\$5,046	\$13,250*
All Large Firms (200 or More Workers)	421	1,170*	5,050	14,038*
<b>ALL FIRM SIZES</b>	<b>\$421</b>	<b>\$1,147</b>	<b>\$5,049</b>	<b>\$13,770</b>

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimates are statistically different within plan type between All Small Firms and All Large Firms ( $p < .05$ ).

## EXHIBIT 1.3

## Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Region, 2010

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
<b>HMO</b>				
Northeast	\$480*	\$1,257*	\$5,756*	\$15,082*
Midwest	421	1,197	5,049	14,364
South	414	1,129	4,972	13,550
West	401*	1,142	4,817*	13,703
<b>ALL REGIONS</b>	<b>\$428</b>	<b>\$1,177</b>	<b>\$5,130</b>	<b>\$14,125</b>
<b>PPO</b>				
Northeast	\$457*	\$1,243*	\$5,484*	\$14,917*
Midwest	430	1,204	5,154	14,451
South	404*	1,121*	4,846*	13,448*
West	445	1,157	5,338	13,880
<b>ALL REGIONS</b>	<b>\$427</b>	<b>\$1,169</b>	<b>\$5,124</b>	<b>\$14,033</b>
<b>POS</b>				
Northeast	\$481*	\$1,235	\$5,776*	\$14,820
Midwest	482	1,290*	5,788	15,484*
South	402*	1,029	4,826*	12,347
West	433	1,007	5,197	12,084
<b>ALL REGIONS</b>	<b>\$437</b>	<b>\$1,101</b>	<b>\$5,239</b>	<b>\$13,213</b>
<b>HDHP/SO</b>				
Northeast	\$398	\$1,156	\$4,779	\$13,869
Midwest	359	985	4,313	11,818
South	371	1,029	4,451	12,345
West	372	989	4,459	11,873
<b>ALL REGIONS</b>	<b>\$373</b>	<b>\$1,032</b>	<b>\$4,470</b>	<b>\$12,384</b>
<b>ALL PLANS</b>				
Northeast	\$457*	\$1,235*	\$5,484*	\$14,815*
Midwest	417	1,164	5,009	13,973
South	402*	1,103*	4,820*	13,238*
West	421	1,122	5,056	13,463
<b>ALL REGIONS</b>	<b>\$421</b>	<b>\$1,147</b>	<b>\$5,049</b>	<b>\$13,770</b>

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different within plan type from estimate for all firms not in the indicated region ( $p < .05$ ).

## EXHIBIT 1.4

## Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Industry, 2010

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
<b>HMO</b>				
Agriculture/Mining/Construction	NSD	NSD	NSD	NSD
Manufacturing	\$395*	\$1,159	\$4,744*	\$13,911
Transportation/Communications/ Utilities	412	1,195	4,946	14,336
Wholesale	NSD	NSD	NSD	NSD
Retail	NSD	NSD	NSD	NSD
Finance	396	1,169	4,749	14,032
Service	446	1,134	5,348	13,603
State/Local Government	471	1,269	5,651	15,222
Health Care	457*	1,290*	5,484*	15,476*
<b>ALL INDUSTRIES</b>	<b>\$428</b>	<b>\$1,177</b>	<b>\$5,130</b>	<b>\$14,125</b>
<b>PPO</b>				
Agriculture/Mining/Construction	\$384*	\$1,073*	\$4,608*	\$12,871*
Manufacturing	407	1,171	4,886	14,053
Transportation/Communications/ Utilities	402*	1,143	4,829*	13,712
Wholesale	402	1,158	4,830	13,892
Retail	399	1,038*	4,794	12,456*
Finance	427	1,244*	5,119	14,932*
Service	423	1,163	5,079	13,959
State/Local Government	512*	1,260	6,145*	15,122
Health Care	484*	1,264	5,811*	15,172
<b>ALL INDUSTRIES</b>	<b>\$427</b>	<b>\$1,169</b>	<b>\$5,124</b>	<b>\$14,033</b>
<b>POS</b>				
Agriculture/Mining/Construction	NSD	NSD	NSD	NSD
Manufacturing	NSD	NSD	NSD	NSD
Transportation/Communications/ Utilities	NSD	NSD	NSD	NSD
Wholesale	NSD	NSD	NSD	NSD
Retail	NSD	NSD	NSD	NSD
Finance	NSD	NSD	NSD	NSD
Service	\$443	\$1,088	\$5,310	\$13,055
State/Local Government	NSD	NSD	NSD	NSD
Health Care	NSD	NSD	NSD	NSD
<b>ALL INDUSTRIES</b>	<b>\$437</b>	<b>\$1,101</b>	<b>\$5,239</b>	<b>\$13,213</b>

Continued on next page

EXHIBIT 1.4 *Continued from previous page*

## Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Industry, 2010

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
<b>HDHP/SO</b>				
Agriculture/Mining/Construction	NSD	NSD	NSD	NSD
Manufacturing	\$390	\$1,036	\$4,685	\$12,428
Transportation/Communications/ Utilities	352	987	4,221	11,847
Wholesale	368	1,040	4,419	12,485
Retail	NSD	NSD	NSD	NSD
Finance	346	999	4,147	11,984
Service	376	1,051	4,517	12,615
State/Local Government	NSD	NSD	NSD	NSD
Health Care	377	1,041	4,529	12,497
<b>ALL INDUSTRIES</b>	<b>\$373</b>	<b>\$1,032</b>	<b>\$4,470</b>	<b>\$12,384</b>
<b>ALL PLANS</b>				
Agriculture/Mining/Construction	\$386*	\$1,057*	\$4,628*	\$12,689*
Manufacturing	402	1,144	4,818	13,729
Transportation/Communications/ Utilities	397*	1,133	4,763*	13,591
Wholesale	399	1,143	4,783	13,712
Retail	398	1,032*	4,782	12,387*
Finance	407	1,192	4,883	14,310
Service	423	1,135	5,073	13,619
State/Local Government	488*	1,224	5,852*	14,684
Health Care	459*	1,241*	5,507*	14,888*
<b>ALL INDUSTRIES</b>	<b>\$421</b>	<b>\$1,147</b>	<b>\$5,049</b>	<b>\$13,770</b>

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different within plan type from estimate for all firms not in the indicated industry (p&lt;.05).

NSD: Not Sufficient Data.

## EXHIBIT 1.5

## Average Annual Premiums for Covered Workers with Single Coverage, by Firm Characteristics, 2010

	All Small Firms (3–199 Workers)	All Large Firms (200 or More Workers)	All Firms
<b>Wage Level</b>			
Few Workers Are Lower-Wage (Less Than 35% Earn \$23,000 a Year or Less)	\$5,052	\$5,074	\$5,067
Many Workers are Lower-Wage (35% or More Earn \$23,000 a Year or Less)	\$4,998	\$4,859	\$4,907
<b>Unions</b>			
Firm Has At Least Some Union Workers	\$5,726	\$5,196*	\$5,263*
Firm Does Not Have Any Union Workers	\$4,948	\$4,926*	\$4,936*
<b>Younger Workers</b>			
Less Than 35% of Workers Are Age 26 or Younger	\$5,043	\$5,080*	\$5,067
35% or More Workers Are Age 26 or Younger	\$5,092	\$4,724*	\$4,827
<b>Older Workers</b>			
Less Than 35% of Workers Are Age 50 or Older	\$4,825*	\$4,969*	\$4,918*
35% or More Workers Are Age 50 or Older	\$5,466*	\$5,200*	\$5,291*
<b>Funding Arrangement</b>			
Fully Insured	\$4,972	\$5,286*	\$5,060
Self-Funded	\$5,428	\$5,001*	\$5,041

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimates are statistically different from each other within firm size category ( $p < .05$ ).

## EXHIBIT 1.6

## Average Annual Premiums for Covered Workers with Family Coverage, by Firm Characteristics, 2010

	All Small Firms (3–199 Workers)	All Large Firms (200 or More Workers)	All Firms
<b>Wage Level</b>			
Few Workers Are Lower-Wage (Less Than 35% Earn \$23,000 a Year or Less)	\$13,358	\$14,021	\$13,795
Many Workers are Lower-Wage (35% or More Earn \$23,000 a Year or Less)	\$12,411	\$14,174	\$13,567
<b>Unions</b>			
Firm Has At Least Some Union Workers	\$14,858*	\$14,249	\$14,327*
Firm Does Not Have Any Union Workers	\$13,010*	\$13,857	\$13,472*
<b>Younger Workers</b>			
Less Than 35% of Workers Are Age 26 or Younger	\$13,241	\$14,113*	\$13,811
35% or More Workers Are Age 26 or Younger	\$13,406	\$13,195*	\$13,252
<b>Older Workers</b>			
Less Than 35% of Workers Are Age 50 or Older	\$12,908*	\$13,791*	\$13,489*
35% or More Workers Are Age 50 or Older	\$13,888*	\$14,490*	\$14,286*
<b>Funding Arrangement</b>			
Fully Insured	\$13,203	\$14,678*	\$13,626
Self-Funded	\$13,493	\$13,903*	\$13,865

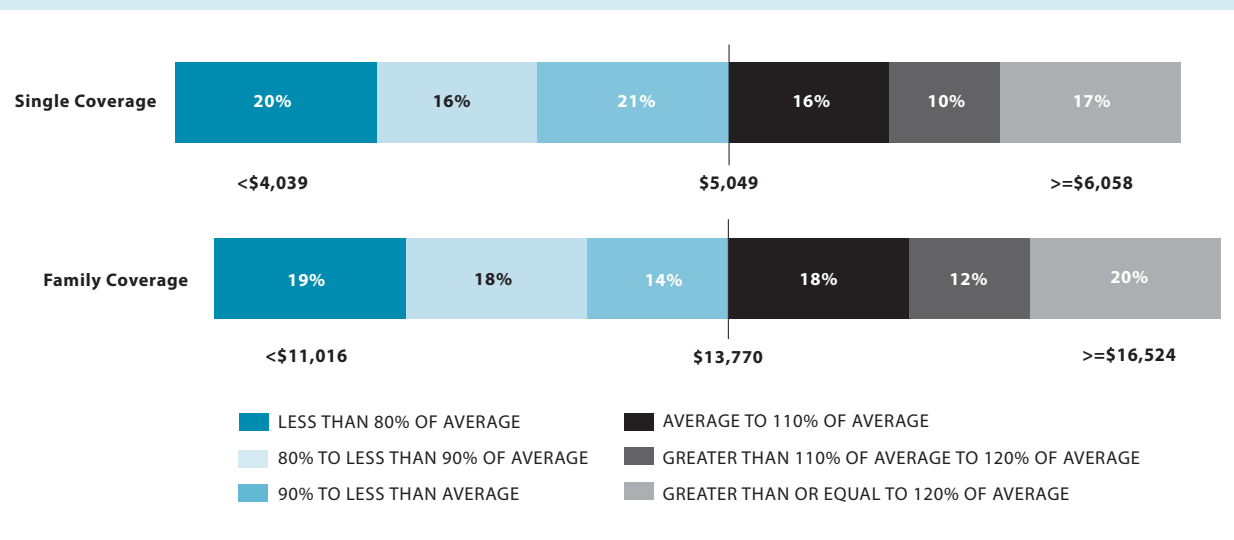
## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimates are statistically different from each other within firm size category (p&lt;.05).

## EXHIBIT 1.7

Distribution of Annual Premiums for Single and Family Coverage Relative to the Average Annual Single or Family Premium, 2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

## EXHIBIT 1.8

Distribution of Premiums for Single and Family Coverage Relative to the Average Annual Single or Family Premium, 2010

	Single Coverage		Family Coverage	
Premium Range, Relative to Average Premium	Premium Range, Dollar Amount	Percent Covered Workers in Range	Premium Range, Dollar Amount	Percent Covered Workers in Range
Less than 80%	Less Than \$4,039	20%	Less Than \$11,016	19%
80% to Less Than 90%	\$4,039 to <\$4,544	16%	\$11,016 to <\$12,393	18%
90% to Less Than Average	\$4,544 to <\$5,049	21%	\$12,393 to <\$13,770	14%
Average to Less Than 110%	\$5,049 to <\$5,554	16%	\$13,770 to <\$15,147	18%
110% to Less Than 120%	\$5,554 to <\$6,058	10%	\$15,147 to <\$16,524	12%
120% or More	\$6,058 or More	17%	\$16,524 or More	20%

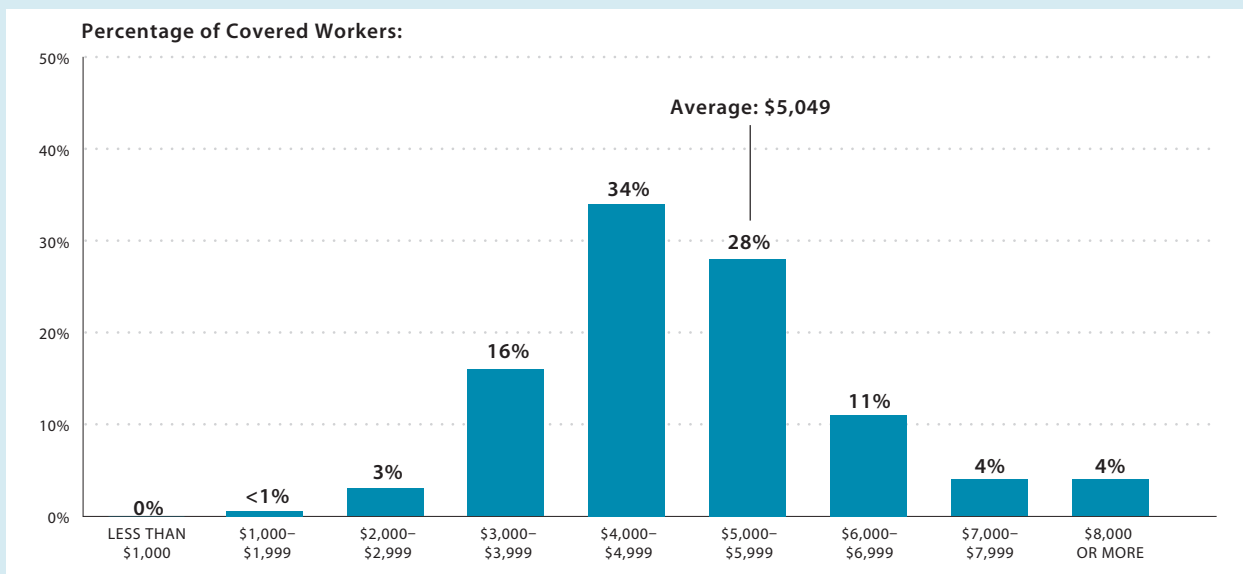
SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

Note: The average premium is \$5,049 for single coverage and \$13,770 for family coverage. The premium distribution is relative to the average single or family premium. For example, \$4,039 is 80% of the average single premium, \$4,544 is 90% of the average single premium, \$5,554 is 110% of the average single premium, and \$6,058 is 120% of the average single premium. The same break points relative to the average are used for the distribution for family coverage.

EXHIBIT 1.9

Distribution of Annual Premiums for Covered Workers with Single Coverage, 2010

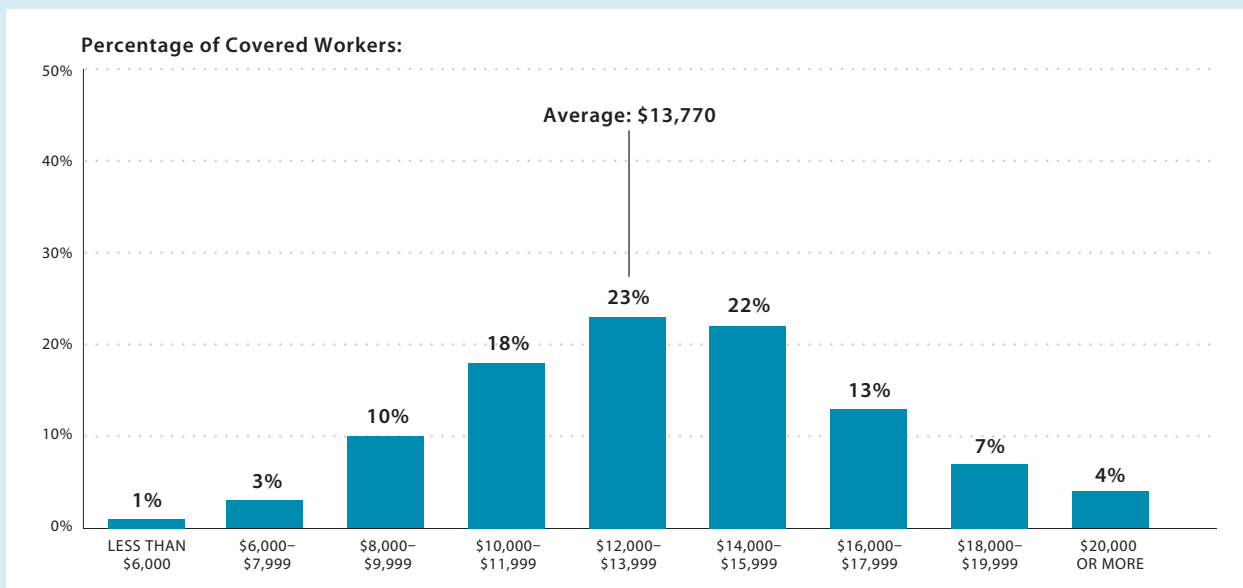


SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

EXHIBIT 1.10

Distribution of Annual Premiums for Covered Workers with Family Coverage, 2010

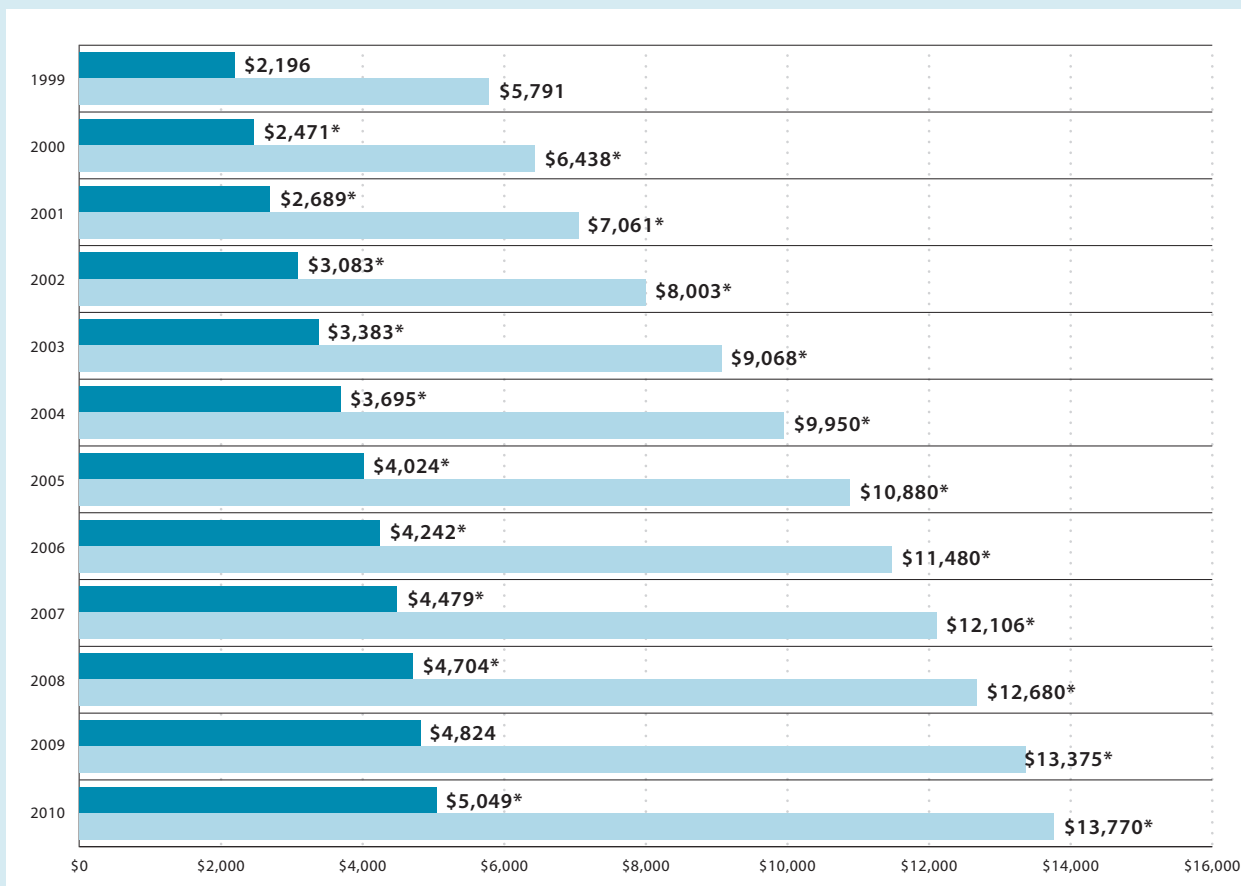


SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

EXHIBIT 1.11

Average Annual Premiums for Single and Family Coverage, 1999–2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

■ SINGLE COVERAGE  
■ FAMILY COVERAGE

## EXHIBIT 1.12

## Average Annual Premiums for Covered Workers with Family Coverage, by Firm Size, 1999–2010

	All Small Firms (3–199 Workers)	All Large Firms (200 or More Workers)
1999	\$5,683	\$5,845
2000	\$6,521	\$6,395
2001	\$6,959	\$7,113
2002*	\$7,781	\$8,109
2003	\$8,946	\$9,127
2004	\$9,737	\$10,046
2005*	\$10,587	\$11,025
2006	\$11,306	\$11,575
2007	\$11,835	\$12,233
2008*	\$12,091	\$12,973
2009*	\$12,696	\$13,704
2010*	\$13,250	\$14,038

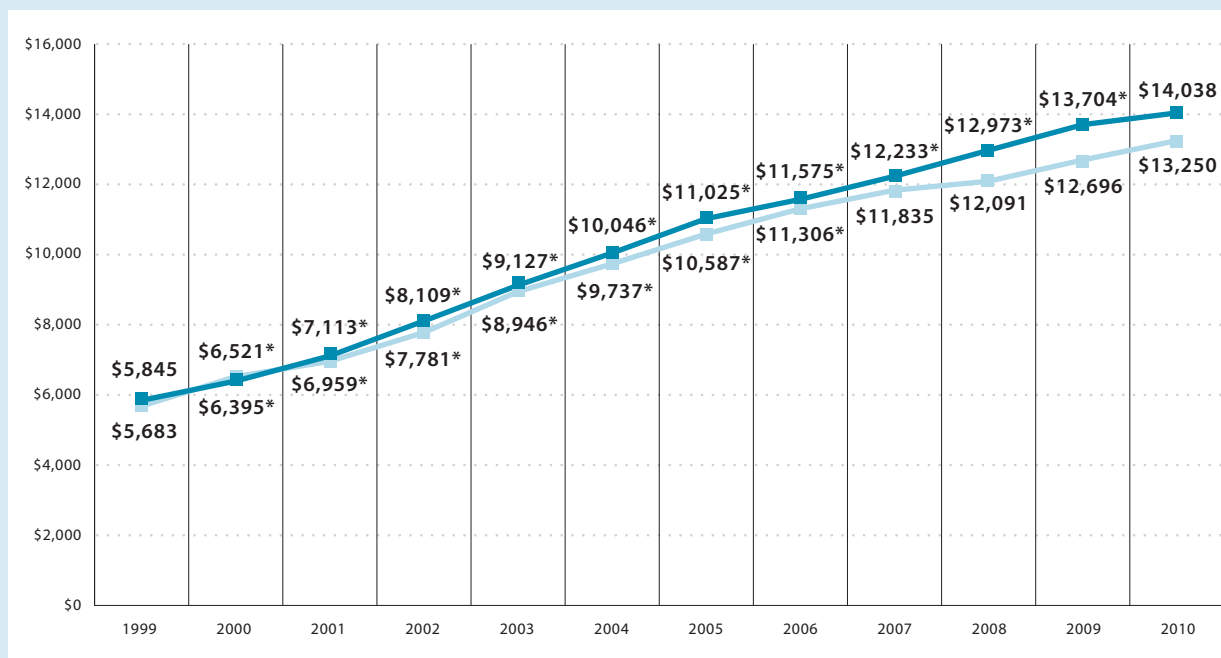
## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Estimate is statistically different between All Small Firms and All Large Firms within year ( $p < .05$ ).

## EXHIBIT 1.13

## Average Annual Premiums for Covered Workers with Family Coverage, by Firm Size, 1999–2010



## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

— ALL SMALL FIRMS  
(3–199 WORKERS)

— ALL LARGE FIRMS  
(200 OR MORE WORKERS)

## EXHIBIT 1.14

Among Workers in Large Firms (200 or More Workers), Average Health Insurance Premiums for Family Coverage, by Funding Arrangement, 1999–2010

Funding Arrangement	Fully Insured	Self-Funded
1999	\$5,769	\$5,896
2000	\$6,315*	\$6,430*
2001	\$7,169*	\$7,086*
2002	\$7,950*	\$8,192*
2003	\$9,070*	\$9,149*
2004	\$10,217*	\$9,984*
2005	\$10,870*	\$11,077*
2006	\$11,222	\$11,673*
2007	\$11,968*	\$12,315*
2008	\$13,029*	\$12,956*
2009	\$13,870*	\$13,655*
2010	\$14,678*	\$13,903

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

Note: For definitions of Self-Funded and Fully Insured Plans, see the introduction to Section 10. Due to a change in the survey questionnaire, funding status was not asked of firms with conventional plans in 2006. Therefore, conventional plan funding status is not included in this exhibit for 2006.



EMPLOYER HEALTH BENEFITS  
2010 ANNUAL SURVEY

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Health  
Benefits  
Offer Rates

---

SECTION

2

## HEALTH BENEFITS OFFER RATES

NEARLY ALL LARGE FIRMS (200 OR MORE WORKERS) OFFER HEALTH BENEFITS; SMALL FIRMS (3–199 WORKERS) ARE SIGNIFICANTLY LESS LIKELY TO DO SO.

THE PERCENTAGE OF FIRMS OFFERING HEALTH BENEFITS IN 2010 INCREASED SIGNIFICANTLY FROM 2009. THE REASON FOR THE INCREASE IS UNCLEAR, BUT IT IS PRIMARILY DRIVEN BY A 13 PERCENTAGE POINT JUMP IN THE PERCENTAGE OF FIRMS WITH 3 TO 9 EMPLOYEES OFFERING COVERAGE, FROM 46% IN 2009 TO 59% IN 2010. WE HAVE SEEN SOME FLUCTUATION IN THIS CATEGORY IN THE PAST BUT NEVER OF THIS MAGNITUDE. THE OFFER RATE REFLECTS INFORMATION ABOUT FIRMS THAT ARE STILL IN BUSINESS IN 2010 AND DOES NOT ACCOUNT FOR FIRMS THAT HAVE GONE OUT OF BUSINESS DUE TO THE ECONOMIC RECESSION. A POSSIBLE EXPLANATION FOR THE INCREASE IN THE OFFER RATE IS THAT NON-OFFERING FIRMS WERE MORE LIKELY TO FAIL DURING THE PAST YEAR, AND THE ATTRITION OF NON-OFFERING FIRMS LED TO A HIGHER OFFER RATE AMONG SURVIVING FIRMS. FOR MORE DISCUSSION OF THE OFFER RATE, SEE THE SURVEY DESIGN AND METHODS SECTION. BECAUSE MOST WORKERS ARE EMPLOYED BY LARGE FIRMS, THE CHANGE IN OFFERING AMONG THE SMALLEST FIRMS DID NOT HAVE A DRAMATIC EFFECT ON THE PERCENTAGE OF WORKERS IN FIRMS OFFERING HEALTH BENEFITS (93 PERCENT IN 2010 VS. 91 PERCENT IN 2009).

- ▶ In 2010, sixty-nine percent of firms offer health benefits, which is statistically different from the 60% reported in 2009 (Exhibit 2.1).
  - Ninety-nine percent of large firms (200 or more workers) offer health benefits in 2010, not statistically different from 2009 (Exhibit 2.2). In contrast, 68% of small firms (3–199 workers) offer health benefits in 2010, a statistically significant increase from the 59% reported in 2009.
  - Between 1999 and 2010, the offer rate for large firms (200 or more workers) has not dropped below 98%. Among small firms (3–199 workers), the offer rate has varied from a high of 68% in 2000, 2001 and 2010, to a low of 59% in 2005, 2007 and 2009. These variations are driven primarily by changes in the percentages of the smallest firms (3–9 workers) offering health benefits.
- ▶ Offer rates vary across different types of firms.
  - The smallest firms are least likely to offer health insurance. Fifty-nine percent of firms with 3 to 9 workers offer coverage, compared to 76% of firms with 10 to 24 workers, 92% of firms with 25 to 49 workers (Exhibit 2.3), and over 95% of firms with 50 or more employees.
  - Firms with fewer lower-wage workers (less than 35% of workers earn \$23,000 or less annually) are significantly more likely to offer health insurance than firms with many lower-wage workers (35% or more of workers earn \$23,000 or less annually). Seventy-four percent of firms with fewer lower-wage workers offer health benefits, compared with only 48% of firms with many lower-wage workers (Exhibit 2.4).
  - Firms that employ at least some union workers are much more likely than firms without union workers to offer health benefits to their employees. Ninety-four percent of firms with some union workers offer health benefits, compared to 67% of firms that do not have union employees (Exhibit 2.4).
  - The age of the workforce significantly affects the probability of a firm offering health benefits as well. Firms with 35% or more of its workers age 26 or younger are far less likely to offer health benefits than firms where less than 35% of workers are age 26 or younger (31% and 73%, respectively) (Exhibit 2.4).

- ▶ Among firms offering health benefits, relatively few offer benefits to their part-time and temporary workers.
  - In 2010, 25% of all firms that offer health benefits offer them to part-time workers (Exhibit 2.5). Firms with 200 or more workers are more likely to offer health benefits to part-time employees than firms with 3 to 199 workers (42% vs. 24%).
  - A very small percentage (2%) of firms offering health benefits offer them to temporary workers (Exhibit 2.6), and this figure has remained stable over time. Firms with 200 or more workers are more likely to offer health benefits to temporary workers than firms with 3 to 199 workers (7% vs. 1%).

#### DENTAL AND VISION BENEFITS

- ▶ Forty-seven percent of firms offering health benefits offer or contribute to a dental insurance benefit for their employees that is separate from any dental coverage the health plans might include. This is not statistically different from the 44% reported in 2008, which is the last time we asked about dental benefits (Exhibit 2.8). Large firms (200 or more workers) are far more likely than small firms (3–199 workers) to offer or contribute to a separate dental health benefit, at 87% versus 45% (Exhibit 2.7).
- ▶ Eighteen percent of firms offer or contribute to a vision benefit for their employees that is separate from any vision coverage the health plan might include, similar to the 17% reported in 2008, which is the last time we asked about vision benefits (Exhibit 2.8). Large firms (200 or more workers) are much more likely than small firms (3–199 workers) to offer or contribute to a separate vision care benefit, at 55% versus 17% (Exhibit 2.7).

#### FIRMS NOT OFFERING HEALTH BENEFITS

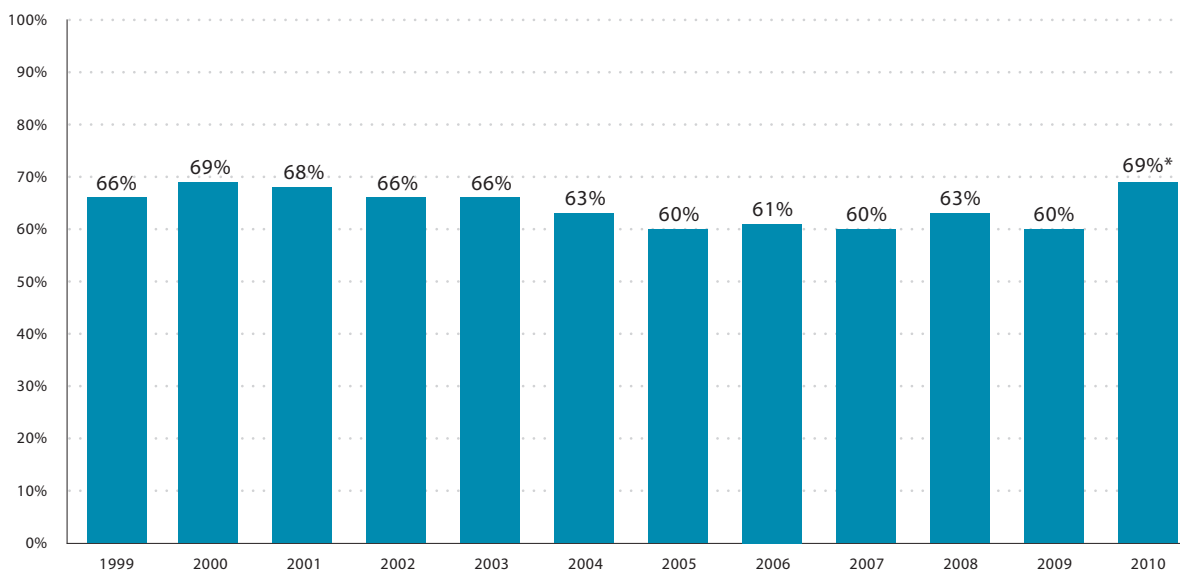
- ▶ The survey asks firms that do not offer health benefits if they have offered insurance or shopped for insurance in the recent past, whether the firm stopped offering due to the recent economic downturn, and about their most important reasons for not offering. Because such a small percentage of large firms (200 or more workers) report not offering health benefits, we present the information for employers with 3 to 199 workers, 32% of which do not offer health benefits.
- ▶ Despite a slowing of health insurance cost growth in recent years, the cost of health insurance remains the primary reason cited by firms for not offering health benefits.<sup>1</sup>
  - Among small firms (3–199 workers) not offering health benefits, 54% cite high cost as “the most important reason” for not doing so. Other factors frequently cited by firms as the most important reason for not offering coverage include: firm is too small (12%) and employees are covered elsewhere (6%) (Exhibit 2.9).
- ▶ Many non-offering firms have either offered health benefits in the past five years, or shopped for coverage recently.
  - Twenty-seven percent of non-offering small firms (3–199 workers) have offered health benefits in the past five years, while 30% have shopped for coverage in the past year (Exhibit 2.10). Forty-seven percent of those that stopped offering within the past five years reported doing so due to the economic downturn.

#### NOTE:

<sup>1</sup> The question asking non-offering firms their most important reason for not offering health benefits is an open-ended question.

## EXHIBIT 2.1

## Percentage of Firms Offering Health Benefits, 1999–2010



## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

Note: As noted in the Survey Design and Methods section, estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

## EXHIBIT 2.2

## Percentage of Firms Offering Health Benefits, by Firm Size, 1999–2010

FIRM SIZE	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
3–9 Workers	56%	57%	58%	58%	55%	52%	47%	48%	45%	49%	46%	59%*
10–24 Workers	74	80	77	70*	76	74	72	73	76	78	72	76
25–49 Workers	86	91	90	86	84	87	87	87	83	90*	87	92
50–199 Workers	97	97	96	95	95	92	93	92	94	94	95	95
All Small Firms (3–199 Workers)	65%	68%	68%	66%	65%	63%	59%	60%	59%	62%	59%	68%*
All Large Firms (200 or More Workers)	99%	99%	99%	98%	98%	99%	98%	98%	99%	99%	98%	99%
ALL FIRMS	66%	69%	68%	66%	66%	63%	60%	61%	60%	63%	60%	69%*

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

Note: As noted in the Survey Design and Methods section, estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

## EXHIBIT 2.3

## Percentage of Firms Offering Health Benefits, by Firm Size, Region, and Industry, 2010

	Percentage of Firms Offering Health Benefits
<b>FIRM SIZE</b>	
3–9 Workers	59%*
10–24 Workers	76*
25–49 Workers	92*
50–199 Workers	95*
200–999 Workers	98*
1,000–4,999 Workers	99*
5,000 or More Workers	99*
<b>All Small Firms (3–199 Workers)</b>	<b>68%*</b>
<b>All Large Firms (200 or More Workers)</b>	<b>99%*</b>
<b>REGION</b>	
Northeast	78%*
Midwest	63
South	67
West	70
<b>INDUSTRY</b>	
Agriculture/Mining/Construction	67%
Manufacturing	78
Transportation/Communications/Utilities	85
Wholesale	79
Retail	57
Finance	71
Service	72
State/Local Government	72
Health Care	57*
<b>ALL FIRMS</b>	<b>69%</b>

## SOURCE:

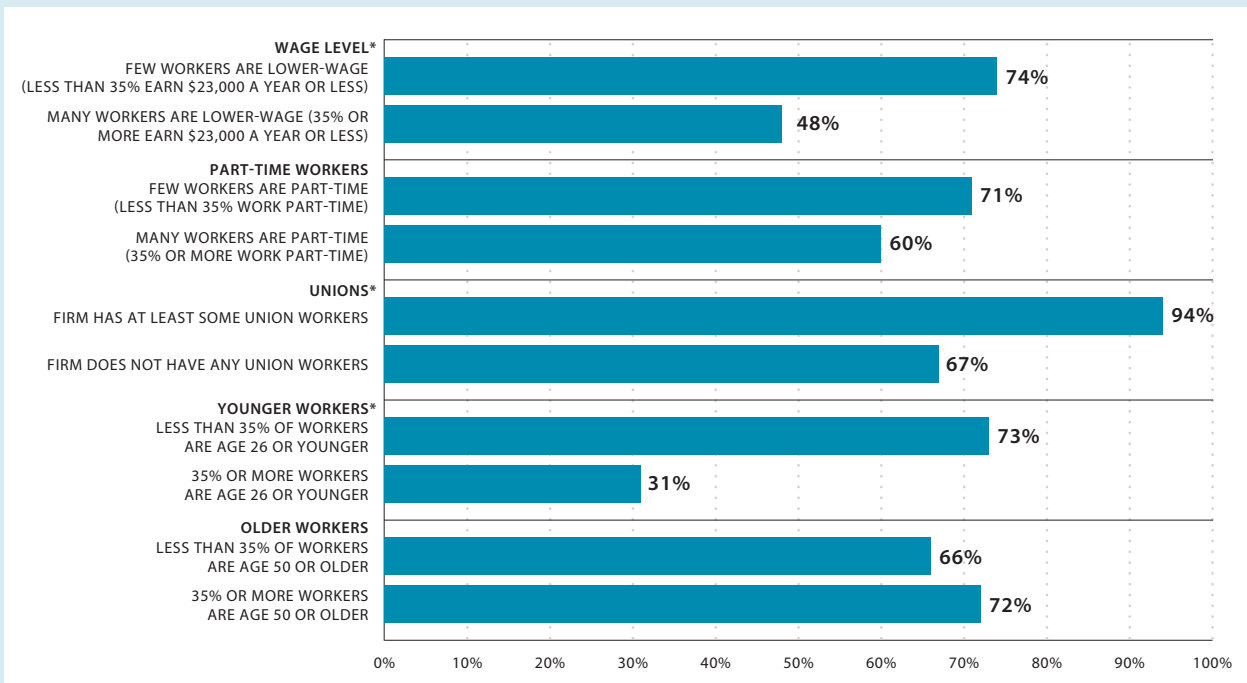
Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different from estimate for all other firms not in the indicated size, region, or industry category ( $p < .05$ ).

Note: As noted in the Survey Design and Methods section, estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

EXHIBIT 2.4

Percentage of Firms Offering Health Benefits, by Firm Characteristics, 2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimates are statistically different from each other within category ( $p < .05$ ).

## EXHIBIT 2.5

Among Firms Offering Health Benefits, Percentage That Offer Health Benefits to Part-Time Workers, by Firm Size, 1999–2010

FIRM SIZE	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
3–24 Workers	19%	21%	17%	21%	24%	20%	27%	30%	23%	22%	31%	24%
25–199 Workers	26	25	31	29	29	29	29	28	26	30	27	28
200–999 Workers	36	33	42	43	38	41	33	40	37	40	44	35*
1,000–4,999 Workers	53	48	55	60	57	50	46	55	54	53	55	55
5,000 or More Workers	61	52	60	58	57	59	61	63	63	67	60	61
<b>ALL FIRMS</b>	<b>21%</b>	<b>23%</b>	<b>21%</b>	<b>24%</b>	<b>26%</b>	<b>23%</b>	<b>28%</b>	<b>31%</b>	<b>24%</b>	<b>25%</b>	<b>31%</b>	<b>25%</b>

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

## EXHIBIT 2.6

Among Firms Offering Health Benefits, Percentage That Offer Health Benefits to Temporary Workers, by Firm Size, 1999–2010

FIRM SIZE	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
3–24 Workers	5%	2%	4%	3%	1%	4%	2%	3%	2%	3%	4%	1%
25–199 Workers	3	7	3	4	3	3	5	4	4	3	3	4
200–999 Workers	3	8	6	5	9	8	5	5	7	4	4	6
1,000–4,999 Workers	6	8	9	8	7	6	5	9	9	7	7	8
5,000 or More Workers	8	9	7	7	10	7	9	11	6*	8	9	8
<b>ALL FIRMS</b>	<b>4%</b>	<b>4%</b>	<b>4%</b>	<b>3%</b>	<b>2%</b>	<b>4%</b>	<b>3%</b>	<b>3%</b>	<b>2%</b>	<b>3%</b>	<b>3%</b>	<b>2%</b>

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

EXHIBIT 2.7

Among Firms Offering Health Benefits, Percentage That Offer or Contribute to a Separate Benefit Plan Providing Dental or Vision Benefits, by Firm Size and Region, 2010

	Separate Dental Benefits	Separate Vision Benefits
<b>FIRM SIZE</b>		
200–999 Workers	87%*	51%*
1,000–4,999 Workers	88*	64*
5,000 or More Workers	90*	68*
<b>All Small Firms (3–199 Workers)</b>	<b>45%*</b>	<b>17%*</b>
<b>All Large Firms (200 or More Workers)</b>	<b>87%*</b>	<b>55%*</b>
<b>REGION</b>		
Northeast	49%	13%
Midwest	41	11*
South	56	19
West	36	27
<b>ALL FIRMS</b>	<b>47%</b>	<b>18%</b>

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different from estimate for all firms not in the indicated size or region category ( $p < .05$ ).

Note: The survey asks firms that offer health benefits if they offer or contribute to a dental or vision insurance program that is separate from any dental or vision coverage the health plans might include.

## EXHIBIT 2.8

Among Firms Offering Health Benefits, Percentage That Offer or Contribute to a Separate Benefit Plan Providing Dental or Vision Benefits, by Firm Size, 2000–2010

	2000	2003	2006	2008	2010
<b>Dental Benefits</b>					
All Small Firms (3–199 workers)	30%	37%	49%*	43%	45%
All Large Firms (200 or More Workers)	62	79*	80	82	87*
<b>All Firms</b>	<b>31%</b>	<b>39%</b>	<b>50%*</b>	<b>44%</b>	<b>47%</b>
<b>Vision Benefits</b>					
All Small Firms (3–199 workers)	—	—	20%	15%	17%
All Large Firms (200 or More Workers)	—	—	44	49	55*
<b>All Firms</b>	<b>—</b>	<b>—</b>	<b>21%</b>	<b>17%</b>	<b>18%</b>

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000–2010.

\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

Note: Data on vision benefits was not collected in 2000 and 2003. The survey asks firms that offer health benefits if they offer or contribute to a dental or vision insurance program that is separate from any dental or vision coverage the health plans might include.

## EXHIBIT 2.9

Among Small Firms (3–199 Workers) Not Offering Health Benefits, Reasons for Not Offering, 2010

	Most Important Reason
Cost of health insurance is too high	54%
The firm is too small	12
Employees are generally covered under another plan	6
Employee turnover is too great	5
No interest/Employees don't want it	4
Other	8
Don't know	11

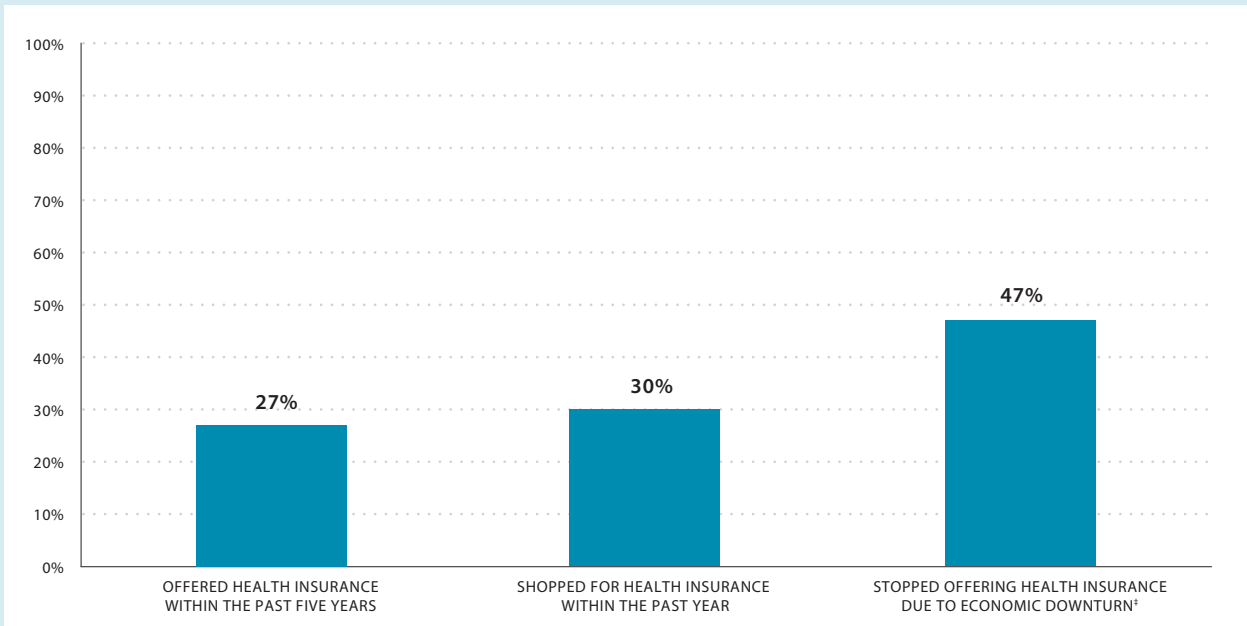
## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

Note: The question asking non-offering firms their most important reason for not offering health benefits is an open-ended question.

EXHIBIT 2.10

Among Small Firms (3–199 Workers) Not Offering Health Benefits, Percentage That Report the Following Activities Regarding Health Benefits, by Firm Size, 2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

<sup>‡</sup> Among those firms who reported offering health insurance within the past five years.

EMPLOYER HEALTH BENEFITS  
2010 ANNUAL SURVEY

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Employee  
Coverage,  
Eligibility, and  
Participation

---

SECTION

3

## EMPLOYEE COVERAGE, ELIGIBILITY, AND PARTICIPATION

EMPLOYERS ARE THE PRINCIPAL SOURCE OF HEALTH INSURANCE IN THE UNITED STATES, PROVIDING HEALTH BENEFITS FOR ABOUT 157 MILLION NONELDERLY PEOPLE IN AMERICA.<sup>1</sup> MOST WORKERS ARE OFFERED HEALTH COVERAGE AT WORK, AND THE VAST MAJORITY OF WORKERS WHO ARE OFFERED COVERAGE TAKE IT. WORKERS MAY NOT BE COVERED BY THEIR OWN EMPLOYER FOR SEVERAL REASONS: THEIR EMPLOYER MAY NOT OFFER COVERAGE, THEY MAY BE INELIGIBLE FOR BENEFITS OFFERED BY THEIR FIRM, THEY MAY CHOOSE TO ELECT COVERAGE THROUGH THEIR SPOUSE'S EMPLOYER, OR THEY MAY REFUSE AN OFFER OF COVERAGE FROM THEIR FIRM.

- ▶ Among firms offering health benefits, 63% percent of workers are covered by health benefits through their own employer (Exhibit 3.2). This percentage is reduced to 59% when considering all workers, regardless of whether they are in a firm offering health benefits or not (Exhibit 3.1). The coverage rate has remained fairly stable over time.
- ▶ Not all employees are eligible for the health benefits offered by their firm, and not all eligible employees who are offered health coverage take up the offer of coverage. The share of workers covered in a firm is a product of both the percentage of workers who are eligible for the firm's health insurance and the percentage who choose to "take up" (i.e., elect to participate in) the benefit.
  - Seventy-nine percent of workers in firms offering health benefits are eligible for the coverage offered by their employer in 2010, the same as last year (Exhibit 3.2).
  - Eligibility varies considerably by wage level. Employees in firms with a lower proportion of lower-wage workers (less than 35% of workers earn \$23,000 or less annually) are more likely to be eligible for health benefits than employees in firms with a higher proportion of lower-wage workers (where 35% or more of workers earn \$23,000 or less annually) (81% vs. 68%) (Exhibit 3.3).
- ▶ Employees who are offered coverage through their employer generally elect to take up coverage. Eighty percent of eligible workers take up coverage when it is offered to them, similar to the 81% reported last year (Exhibit 3.2).
  - The likelihood of a worker accepting a firm's offer of coverage also varies by firm wage level. Eligible employees in firms with a lower proportion of lower-wage workers are more likely to take up coverage (82%) than eligible employees in firms with a higher proportion of lower-wage workers (35% or more of workers earn \$23,000 or less annually) (69%) (Exhibit 3.4).
- ▶ The rate of coverage varies by certain firm characteristics.
  - There is significant variation in the coverage rate by industry among workers in firms offering health benefits. For example, only forty-eight percent of workers in retail firms are covered by health benefits offered by their firm, compared to 80% of workers in state and local government, 76% of workers in the manufacturing industry, and 74% of workers in the transportation/communications/utilities industry category (Exhibit 3.2).

### NOTE:

<sup>1</sup> Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer*, October 2009.

<sup>2</sup> In 2009, Kaiser/HRET began weighting the percentage of workers that take up coverage by the number of workers eligible for coverage. The historical take up estimates have also been updated. See the Survey Design and Methods Section for more information.

- Among workers in firms offering health benefits, those in firms with relatively few part-time workers (less than 35% of workers are part-time) are much more likely to be covered by their own firm than workers in firms with a greater percentage of part-time workers (70% vs. 38%) (Exhibit 3.5).
- Among workers in firms offering health benefits, those in firms with fewer lower-wage workers (less than 35% of workers earn \$23,000 or less annually) are more likely to be covered by their own firm than workers in firms with many lower-wage workers (35% or more of workers earn \$23,000 or less annually) (66% vs. 47%) (Exhibit 3.5).
- Among workers in firms offering health benefits, those in firms with fewer younger workers (less than 35% of workers are age 26 or younger) are more likely to be covered by their own firm than workers in firms with many younger workers (35% or more of workers are age 26 or younger) (66% vs. 44%) (Exhibit 3.5).
- ▶ Seventy-four percent of covered workers face a waiting period before coverage is available. Covered workers in the Northeast are less likely (64%) than workers in other regions to face a waiting period. Covered workers in retail (90%), health care (86%), and agriculture/mining/construction (85%) firms are more likely than workers in other industries to face a waiting period (Exhibit 3.7).
- The average waiting period among covered workers who face a waiting period is 2.2 months (Exhibit 3.7). Thirty-one percent of covered workers face a waiting period of 3 months or more (Exhibit 3.8).
- ▶ The distribution of covered workers electing single coverage, single plus one coverage, or family coverage is 47%, 19%, and 34% respectively in 2010 (Exhibit 3.9). Workers in small firms (3–199 workers) are significantly more likely to enroll in single coverage and less likely to enroll in family coverage than are workers in large firms (200 or more workers), at 55% versus 42% for single coverage and 30% versus 36% for family coverage (Exhibit 3.10).
- ▶ The survey asked firms about the age at which dependents and dependents who are full-time students are no longer eligible for coverage in the plan with the largest enrollment.
  - Fifty-two percent of firms limit the age at which dependents are no longer eligible for dependent coverage to 18 or 19 years old, and another 19% limit the age to 20 or 21 years of age (Exhibit 3.11).
  - For dependents who are full-time students, the age limit is generally higher. Sixty-six percent of firms limit the age at which full-time students are no longer eligible for dependent coverage to 24 or older (Exhibit 3.12).<sup>3</sup>

## NOTE:

<sup>3</sup> Averages and distributions exclude 1% of firms with no limit on the age at which dependents are no longer eligible for coverage for the plan with the largest enrollment, and 2% of firms that have no limit for dependents that are full-time students.

EXHIBIT 3.1

Percentage of All Workers Covered by Their Employers' Health Benefits, in Firms Both Offering and Not Offering Health Benefits, by Firm Size, 1999–2010\*

FIRM SIZE	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
3–24 Workers	50%	50%	49%	45%	44%	43%	41%	45%	42%	43%	39%	44%
25–49 Workers	56	63	62	57	59	56	55	55	51	57	54	59
50–199 Workers	61	62	67	64	61	56	59	62	59	60	59	60
200–999 Workers	69	69	71	69	68	69	65	66	65	67	63	61
1,000–4,999 Workers	68	68	69	70	69	68	69	68	69	69	67	66
5,000 or More Workers	64	66	69	68	68	67	66	60	63	64	65	63
All Small Firms (3–199 Workers)	55%	57%	58%	54%	53%	50%	50%	53%	50%	52%	49%	52%
All Large Firms (200 or More Workers)	66%	67%	69%	69%	68%	68%	66%	63%	65%	66%	65%	63%
ALL FIRMS	62%	63%	65%	63%	62%	61%	60%	59%	59%	60%	59%	59%

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\*Tests found no statistical difference from estimate for the previous year shown ( $p < .05$ ).

## EXHIBIT 3.2

## Eligibility, Take-Up Rate, and Coverage in Firms Offering Health Benefits, by Firm Size, Region, and Industry, 2010

	Percentage of Workers Eligible For Health Benefits Offered by Their Employer	Percentage of Eligible Workers Who Participate in Their Employers' Plan (Take-Up Rate)	Percentage of Workers Covered by Their Employers' Health Benefits
<b>FIRM SIZE</b>			
3–24 Workers	83%	76%*	63%
25–49 Workers	84*	77	64
50–199 Workers	80	79	63
200–999 Workers	76	81	62
1,000–4,999 Workers	80	83*	66
5,000 or More Workers	76	82	63
<b>All Small Firms (3–199 Workers)</b>	<b>82%*</b>	<b>77%*</b>	<b>63%</b>
<b>All Large Firms (200 or More Workers)</b>	<b>77%*</b>	<b>82%*</b>	<b>63%</b>
<b>REGION</b>			
Northeast	78%	83%*	64%
Midwest	78	80	62
South	80	79	63
West	79	81	64
<b>INDUSTRY</b>			
Agriculture/Mining/Construction	83%	77%	65%
Manufacturing	92*	83	76*
Transportation/Communications/Utilities	87*	85*	74*
Wholesale	78	83	66
Retail	63*	75	48*
Finance	90*	82	74*
Service	74*	77	57*
State/Local Government	86*	93*	80*
Health Care	77	79	61
<b>ALL FIRMS</b>	<b>79%</b>	<b>80%</b>	<b>63%</b>

## SOURCE:

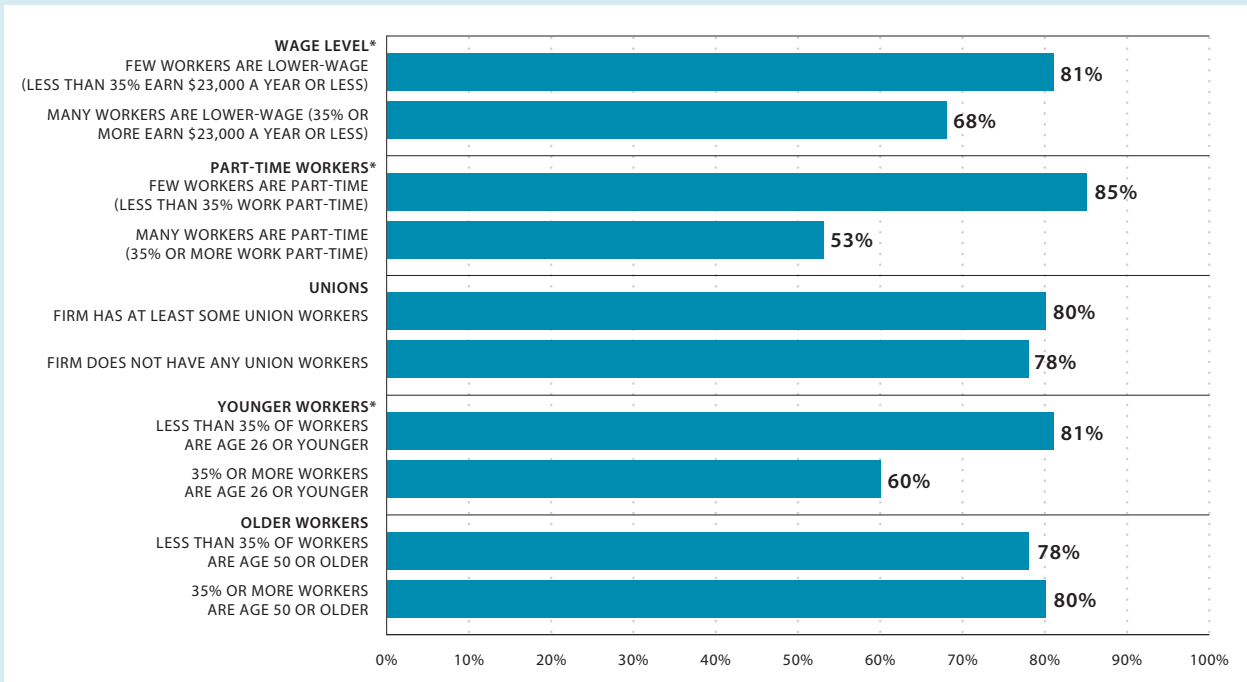
Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate for eligibility, take-up rate, or coverage is statistically different from all other firms not in the indicated size, region, or industry category ( $p < .05$ ).

Note: In 2009, Kaiser/HRET began weighting the percentage of workers that take up coverage by the number of workers eligible for coverage. See the Survey Design and Methods Section for more information.

EXHIBIT 3.3

Among Workers in Firms Offering Health Benefits, Percentage of Workers Eligible for Health Benefits Offered by Their Firm, by Firm Characteristics, 2010



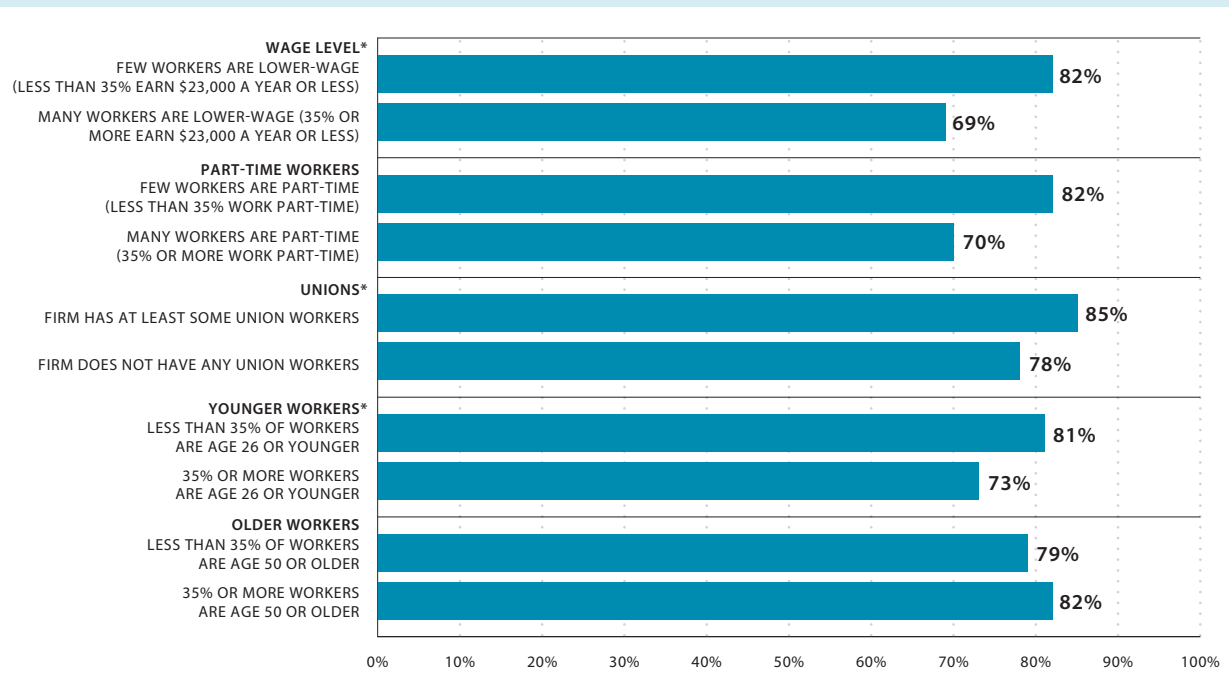
SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimates are statistically different from each other within category ( $p < .05$ ).

## EXHIBIT 3.4

Among Workers in Firms Offering Health Benefits, Percentage of Eligible Workers Who Take Up Health Benefits Offered by Their Firm, by Firm Characteristics, 2010



## SOURCE:

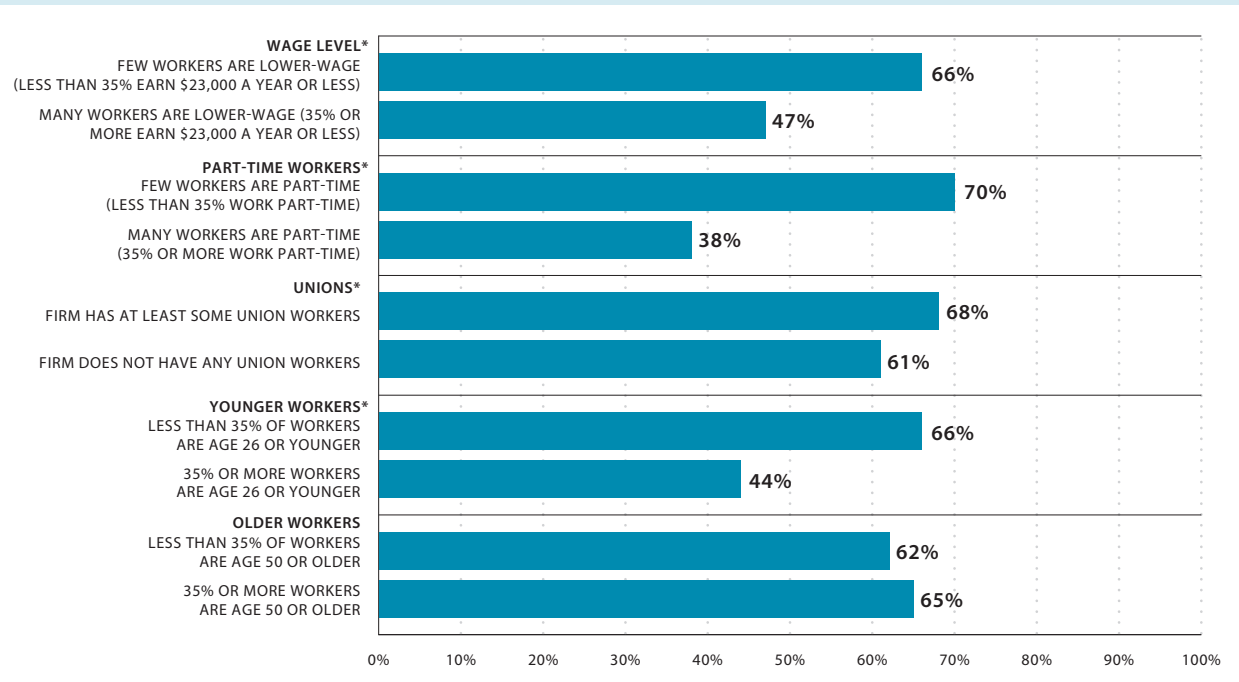
Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimates are statistically different from each other within category ( $p < .05$ ).

Note: In 2009, Kaiser/HRET began weighting the percentage of workers that take up coverage by the number of workers eligible for coverage. See the Survey Design and Methods Section for more information.

EXHIBIT 3.5

Among Workers in Firms Offering Health Benefits, Percentage of Workers Covered by Health Benefits Offered by Their Firm, by Firm Characteristics, 2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimates are statistically different from each other within category ( $p < .05$ ).

## EXHIBIT 3.6

Eligibility, Take-Up Rate, and Coverage for Workers in Firms Offering Health Benefits, by Firm Size, 1999–2010

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
<b>Percentage Eligible</b>												
All Small Firms (3–199 Workers)	81%	82%	85%	82%*	84%	80%	81%	83%	80%	81%	81%	82%
All Large Firms (200 or More Workers)	78	80	82	80	80	81	79	76	78	79	79	77
<b>ALL FIRMS</b>	<b>79%</b>	<b>81%</b>	<b>83%</b>	<b>81%*</b>	<b>81%</b>	<b>80%</b>	<b>80%</b>	<b>78%</b>	<b>79%</b>	<b>80%</b>	<b>79%</b>	<b>79%</b>
<b>Percentage of Eligible that Take Up</b>												
All Small Firms (3–199 Workers)	83%	83%	83%	82%	81%	80%	81%	81%	80%	80%	79%	77%
All Large Firms (200 or More Workers)	86	84	85	86	85	84	85	84	84	84	82	82
<b>ALL FIRMS</b>	<b>85%</b>	<b>84%</b>	<b>84%</b>	<b>85%</b>	<b>84%</b>	<b>83%</b>	<b>83%</b>	<b>83%</b>	<b>82%</b>	<b>82%</b>	<b>81%</b>	<b>80%</b>
<b>Percentage Covered</b>												
All Small Firms (3–199 Workers)	67%	68%	71%	67%	68%	64%	65%	67%	64%	65%	64%	63%
All Large Firms (200 or More Workers)	66	67	69	69	68	68	67	63	65	66	65	63
<b>ALL FIRMS</b>	<b>66%</b>	<b>68%</b>	<b>70%</b>	<b>68%</b>	<b>68%</b>	<b>67%</b>	<b>66%</b>	<b>65%</b>	<b>65%</b>	<b>65%</b>	<b>65%</b>	<b>63%</b>

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

Note: In 2009, Kaiser/HRET began weighting the percentage of workers that take up coverage by the number of workers eligible for coverage. The historical take-up estimates have also been updated. See the Survey Design and Methods Section for more information.

EXHIBIT 3.7

Percentage of Covered Workers in Firms with a Waiting Period for Coverage and Average Waiting Period in Months, by Firm Size, Region, and Industry, 2010

	Percentage of Covered Workers in Firms with a Waiting Period	Among Covered Workers with a Waiting Period, Average Waiting Period (Months)
<b>FIRM SIZE</b>		
All Small Firms (3–199 Workers)	76%	2.5*
All Large Firms (200 or More Workers)	73	2.0*
<b>REGION</b>		
Northeast	64%*	2.1
Midwest	74	2.0*
South	78	2.3
West	77	2.4
<b>INDUSTRY</b>		
Agriculture/Mining/Construction	85%*	2.8*
Manufacturing	71	2.3
Transportation/Communications/Utilities	64	2.2
Wholesale	77	2.2
Retail	90*	2.8*
Finance	73	1.9
Service	67*	2.2
State/Local Government	70	1.7*
Health Care	86*	1.9*
<b>ALL FIRMS</b>	<b>74%</b>	<b>2.2</b>

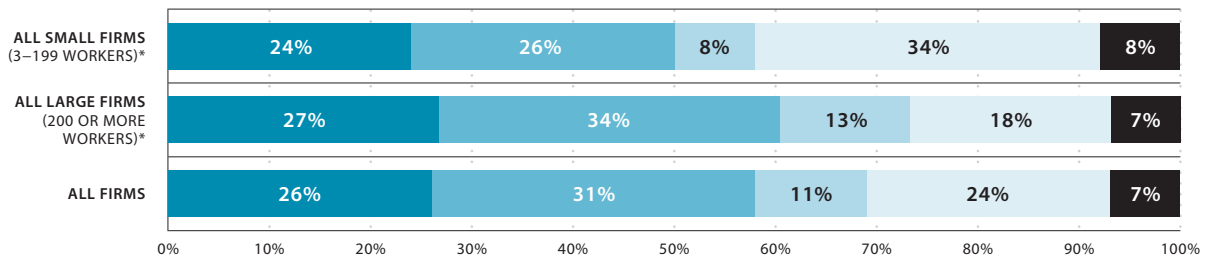
SOURCE:

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different from estimate for all other firms not in the indicated size, region, or industry category ( $p < .05$ ).

EXHIBIT 3.8

Distribution of Covered Workers with the Following Waiting Periods for Coverage, 2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Distributions are statistically different between All Large Firms and All Small Firms ( $p < .05$ ).

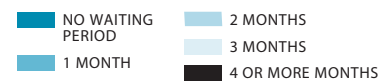
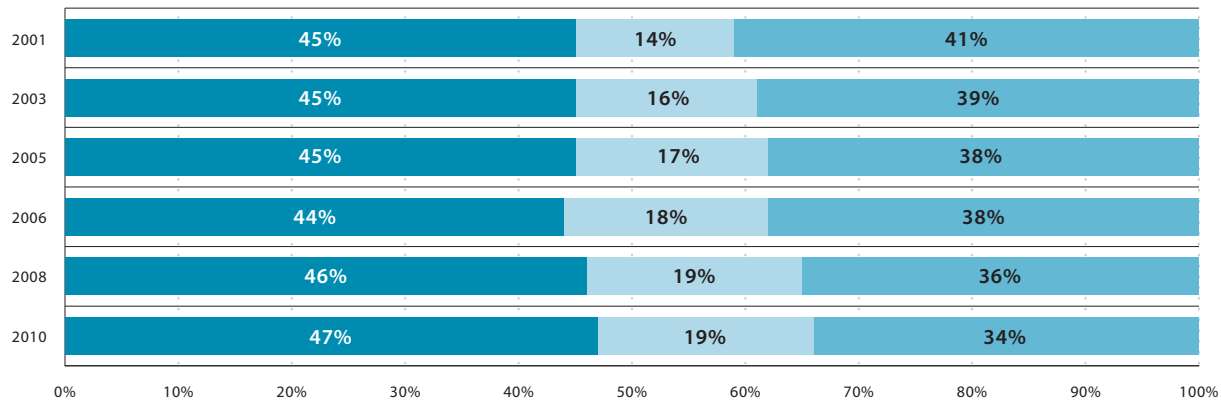


EXHIBIT 3.9

Distribution of Covered Workers Electing Single Coverage, Single Plus One Coverage, or Family Coverage, 2001-2010\*



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2001-2010.

\* Tests found no statistical difference from distribution for previous year shown ( $p < .05$ ).

Note: Single Plus One coverage includes either an employee plus a spouse or an employee plus a child.

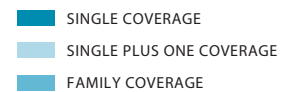
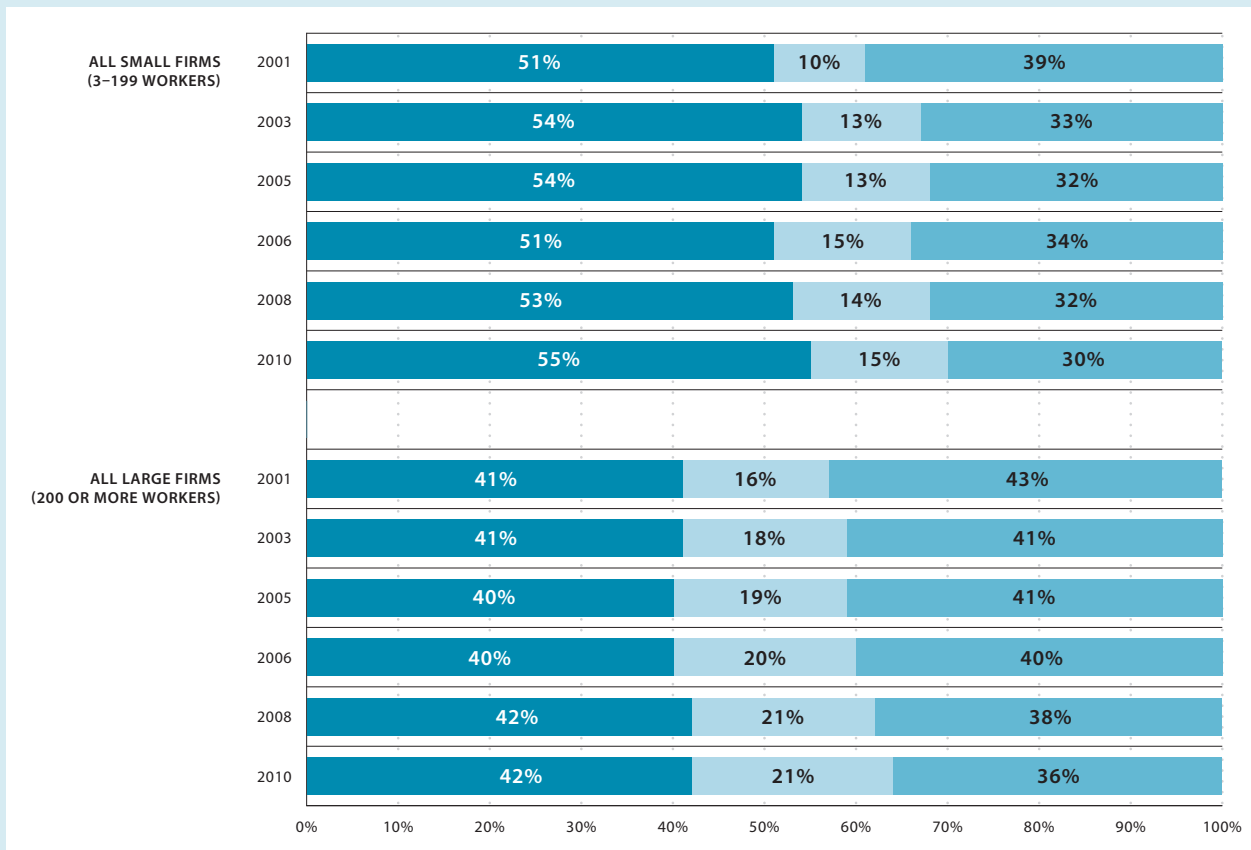


EXHIBIT 3.10

Distribution of Covered Workers Electing Single Coverage, Single Plus One Coverage, or Family Coverage, by Firm Size, 2001–2010\*



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2001–2010.

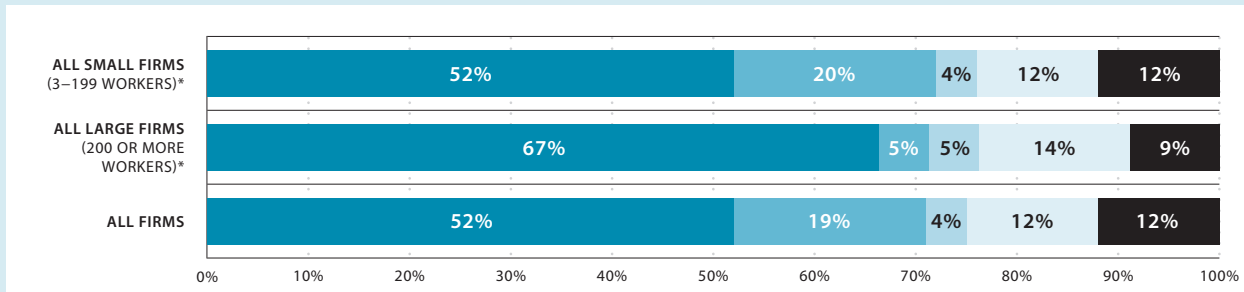
\* Tests found no statistical difference within size category from distribution for previous year shown ( $p < .05$ ).

Note: Single Plus One coverage includes either an employee plus a spouse or an employee plus a child.

■ SINGLE COVERAGE  
■ SINGLE PLUS ONE COVERAGE  
■ FAMILY COVERAGE

EXHIBIT 3.11

Distribution of Firms with the Following Age Limits for Dependent Coverage for the Plan with the Largest Enrollment, 2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Distributions are statistically different between All Large Firms and All Small Firms ( $p < .05$ ).

Note: Distributions exclude those firms (1%) with no limit on the age at which dependents no longer are eligible for coverage for the plan with the largest enrollment.

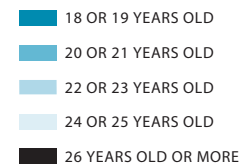
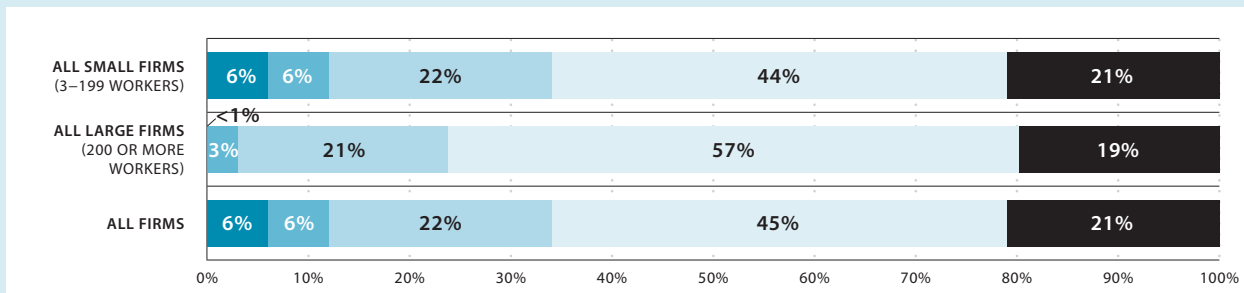


EXHIBIT 3.12

Distribution of Firms with the Following Age Limits for Dependent Coverage for Full-Time Students for the Plan with the Largest Enrollment, 2010\*

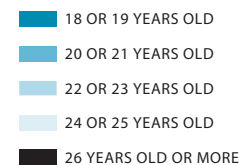


SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Tests found no statistical difference between distributions for All Large Firms and All Small Firms ( $p < .05$ ).

Note: Distributions exclude those firms (2%) with no limit on the age at which dependents who are full-time students no longer are eligible for coverage for the plan with the largest enrollment.





EMPLOYER HEALTH BENEFITS  
2010 ANNUAL SURVEY

Types of  
Plans  
Offered

SECTION

4

## TYPES OF PLANS OFFERED

MOST FIRMS THAT OFFER HEALTH BENEFITS OFFER ONLY ONE TYPE OF HEALTH PLAN (84%) (SEE TEXT BOX). LARGER FIRMS ARE MORE LIKELY TO OFFER MORE THAN ONE TYPE OF HEALTH PLAN. EMPLOYERS ARE MOST LIKELY TO OFFER THEIR WORKERS A PPO, HMO, OR POS PLAN AND ARE LEAST LIKELY TO OFFER A CONVENTIONAL PLAN.

- ▶ Eighty-four percent of firms offering health benefits offer only one type of health plan. Large firms (200 or more workers) are more likely to offer more than one plan type than small firms (3–199 workers): 44% vs. 15% (Exhibit 4.1).
- ▶ Just over half (52%) of covered workers are employed in a firm that offers more than one health plan type. Sixty-seven percent of covered workers in large firms are employed by a firm that offers more than one plan type, compared to 24% in small firms (Exhibit 4.2).
- ▶ About four in five (79%) covered workers in firms offering health benefits work in a firm that offers one or more PPOs; 42% work in firms that offer one or more HMOs; 32% work in firms that offer one or more HDHP/SOs; 14% work in firms that offer one or more POS plans; and 6% work in firms that offer one or more conventional plans (Exhibit 4.4).<sup>1</sup>

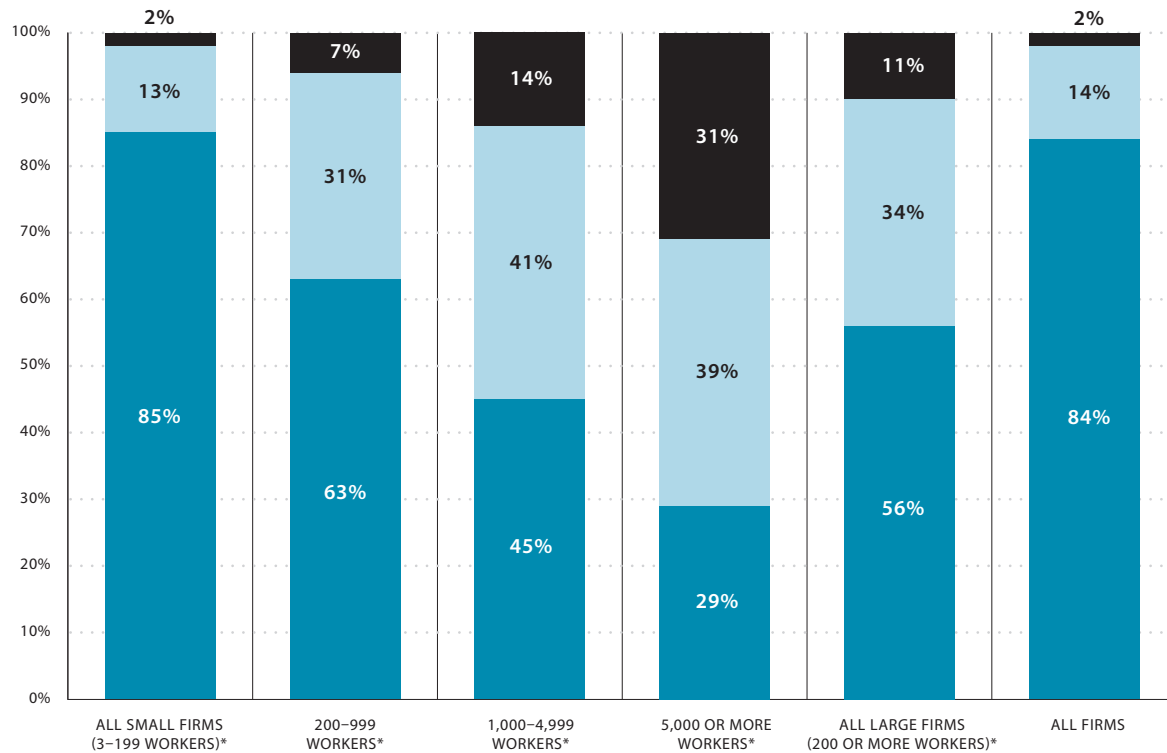
The survey asks firms how many plans of each given type they offer. However, we do not know if each plan type is offered to all covered workers at the firm. For example, some workers might be offered one type of plan at one location, while workers at another location are offered a different type of plan.

### NOTE:

<sup>1</sup> This year we include firms that said they offer a plan type even if there are no covered workers in that plan type.

EXHIBIT 4.1

Among Firms Offering Health Benefits, Percentage of Firms That Offer One, Two, or Three or More Plan Types, by Firm Size, 2010<sup>‡</sup>



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Distribution is statistically different from distribution for all other firms not in the indicated size category ( $p < .05$ ).

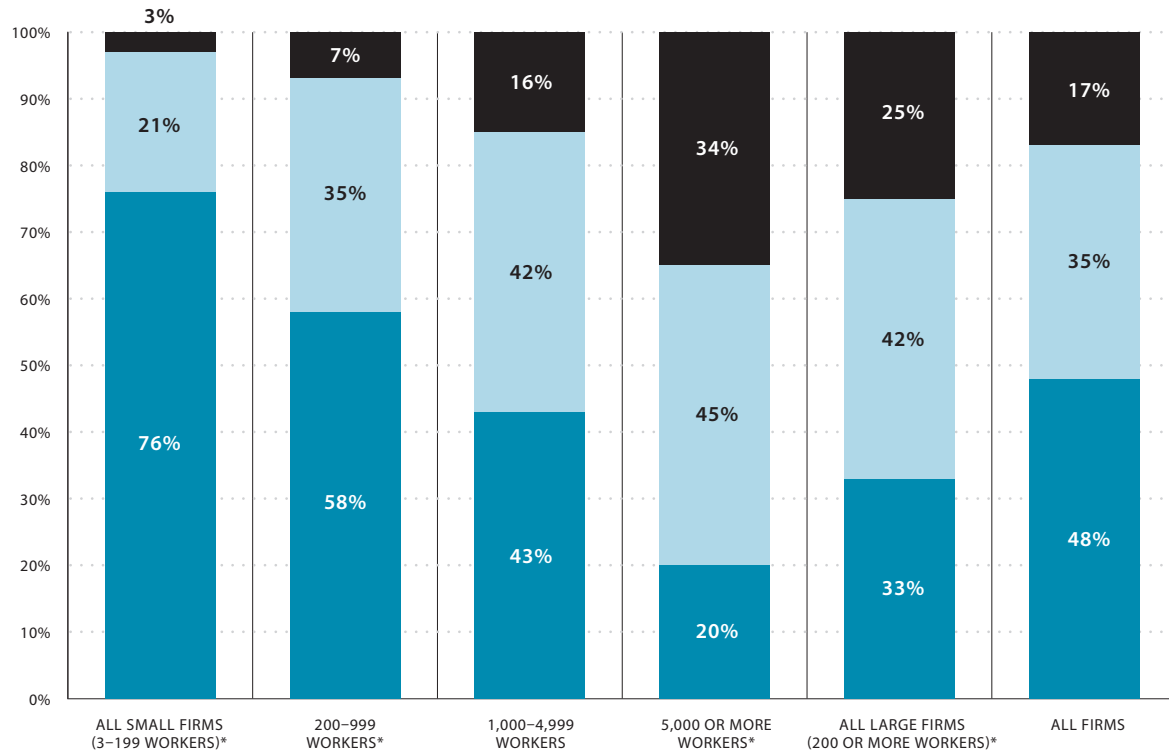
<sup>‡</sup> Although firms may offer more than one of each plan type, the survey asks how many are offered among the following types: conventional, HMO, PPO, POS, and HDHP/SO.

Note: The survey asks firms how many plans of each given type they offer. However, we do not know if each plan type is offered to all covered workers at the firm. For example, some workers might be offered one type of plan at one location, while at another location they are offered a different type of plan.

THREE OR MORE PLAN TYPES  
TWO PLAN TYPES  
ONE PLAN TYPE

EXHIBIT 4.2

Among Firms Offering Health Benefits, Percentage of Covered Workers in Firms Offering One, Two, or Three or More Plan Types, by Firm Size, 2010<sup>‡</sup>



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Distribution is statistically different from distribution for all other firms not in the indicated size category ( $p < .05$ ).

<sup>‡</sup> Although firms may offer more than one of each plan type, the survey asks how many are offered among the following types: conventional, HMO, PPO, POS, and HDHP/SO.

Note: The survey asks firms how many plans of each given type they offer. However, we do not know if each plan type is offered to all covered workers at the firm. For example, some workers might be offered one type of plan at one location, while at another location they are offered a different type of plan.

THREE OR MORE PLAN TYPES  
TWO PLAN TYPES  
ONE PLAN TYPE

## EXHIBIT 4.3

Among Firms Offering Health Benefits, Percentage of Firms That Offer the Following Plan Types, by Firm Size, 2010

	Conventional	HMO	PPO	POS	HDHP/SO
<b>FIRM SIZES</b>					
200–999 Workers	3%	27%	80%*	13%*	21%
1,000–4,999 Workers	5*	39*	89*	8*	30*
5,000 or More Workers	7*	55*	93*	11*	41*
<b>All Small Firms (3–199 Workers)</b>	<b>2%</b>	<b>24%</b>	<b>51%*</b>	<b>25%*</b>	<b>15%*</b>
<b>All Large Firms (200 or More Workers)</b>	<b>3%</b>	<b>32%</b>	<b>83%*</b>	<b>12%*</b>	<b>25%*</b>
<b>ALL FIRMS</b>	<b>2%</b>	<b>24%</b>	<b>53%</b>	<b>25%</b>	<b>15%</b>

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different within plan type from estimate for all other firms not in the indicated size category ( $p < .05$ ).

Note: The survey asks firms how many plans of each given type they offer. However, we do not know if each plan type is offered to all covered workers at the firm. For example, some workers might be offered one type of plan at one location, while workers at another location are offered a different type of plan.

## EXHIBIT 4.4

Among Firms Offering Health Benefits, Percentage of Covered Workers in Firms That Offer the Following Plan Types, by Firm Size, 2010

	Conventional	HMO	PPO	POS	HDHP/SO
<b>FIRM SIZES</b>					
200–999 Workers	2%	31%*	84%	10%*	23%*
1,000–4,999 Workers	4	40	90*	7*	33
5,000 or More Workers	11*	64*	88*	14	45*
<b>All Small Firms (3–199 Workers)</b>	<b>2%*</b>	<b>23%*</b>	<b>62%*</b>	<b>20%*</b>	<b>22%*</b>
<b>All Large Firms (200 or More Workers)</b>	<b>8%*</b>	<b>52%*</b>	<b>88%*</b>	<b>12%*</b>	<b>38%*</b>
<b>ALL FIRMS</b>	<b>6%</b>	<b>42%</b>	<b>79%</b>	<b>14%</b>	<b>32%</b>

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different within plan type from estimate for all other firms not in the indicated size category ( $p < .05$ ).

Note: The survey asks firms how many plans of each given type they offer. However, we do not know if each plan type is offered to all covered workers at the firm. For example, some workers might be offered one type of plan at one location, while workers at another location are offered a different type of plan.



EMPLOYER HEALTH BENEFITS  
2010 ANNUAL SURVEY

Market  
Shares of  
Health Plans

SECTION

5

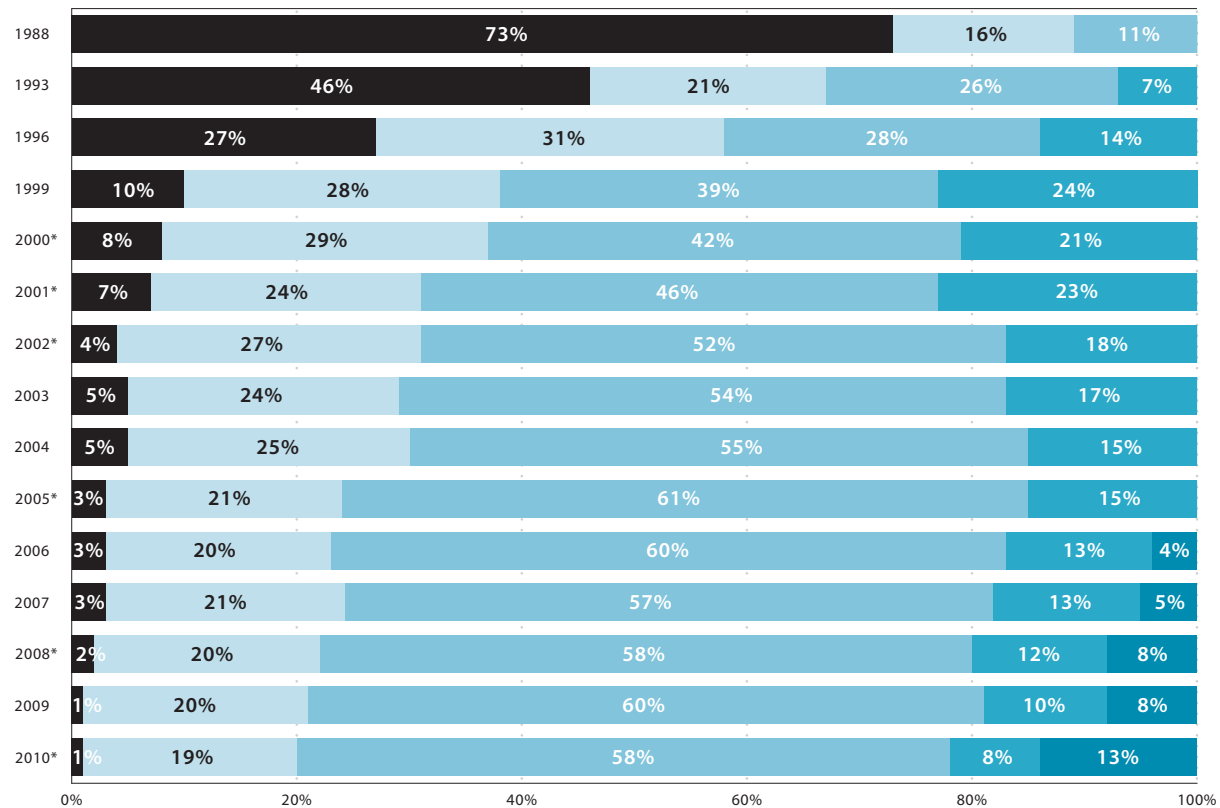
## MARKET SHARES OF HEALTH PLANS

ENROLLMENT REMAINS HIGHEST IN PPOs, WITH MORE THAN HALF OF COVERED WORKERS, FOLLOWED BY HMOs, POS PLANS, HDHP/SOs, AND CONVENTIONAL PLANS.

- ▶ Fifty-eight percent of covered workers are enrolled in PPOs, followed by HMOs (19%), HDHP/SOs (13%), POS plans (8%), and conventional plans (1%) (Exhibit 5.1).
- ▶ Enrollment in HDHP/SOs rose to 13% of covered workers in 2010, up from 8% in 2009 (Exhibit 5.1).
- ▶ Plan enrollment patterns vary by firm size. Workers in large firms (200 or more workers) are more likely than workers in small firms (3–199 workers) to enroll in PPOs (63% vs. 51%). Workers in small firms are more likely than workers in large firms to enroll in POS plans (15% vs. 5%) (Exhibit 5.2).
- ▶ Plan enrollment patterns also differ across regions.
  - HMO enrollment is significantly higher in the West (33%) and Northeast (26%) and significantly lower in the South (12%) and Midwest (11%) (Exhibit 5.2).
  - Workers in the South (67%) are more likely to be enrolled in PPO plans than workers in other regions; workers in the West (47%) are less likely to be enrolled in a PPO (Exhibit 5.2).
  - Enrollment in HDHP/SOs is higher among workers in the Midwest (20%) than in other regions (Exhibit 5.2).

EXHIBIT 5.1

Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988–2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988.

\* Distribution is statistically different from the previous year shown ( $p < .05$ ). No statistical tests were conducted for years prior to 1999. No statistical tests are conducted between 2005 and 2006 due to the addition of HDHP/SO as a new plan type in 2006.

Note: Information was not obtained for POS plans in 1988. A portion of the change in plan type enrollment for 2005 is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local government workers and removing federal workers from the weights. See the Survey Design and Methods Section from the 2005 Kaiser/HRET Survey of Employer-Sponsored Health Benefits for additional information.

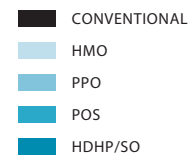


EXHIBIT 5.2

Distribution of Health Plan Enrollment for Covered Workers, by Firm Size, Region, and Industry, 2010

	Conventional	HMO	PPO	POS	HDHP/SO
<b>FIRM SIZE</b>					
3–24 Workers	1%	20%	47%*	16%*	16%
25–49 Workers	1	12*	54	13	19
50–199 Workers	1	18	52	14*	15
200–999 Workers	1	20	63	6	10
1,000–4,999 Workers	1	18	67*	3*	10
5,000 or More Workers	1	21	61	4*	13
<b>All Small Firms (3–199 Workers)</b>	<b>1%</b>	<b>18%</b>	<b>51%*</b>	<b>15%*</b>	<b>16%</b>
<b>All Large Firms (200 or More Workers)</b>	<b>1%</b>	<b>21%</b>	<b>63%*</b>	<b>5%*</b>	<b>12%</b>
<b>REGION</b>					
Northeast	1%	26%*	53%	8%	13%
Midwest	1	11*	62	6	20*
South	1	12*	67*	10	10
West	1	33*	47*	7	12
<b>INDUSTRY</b>					
Agriculture/Mining/Construction	1%	14%	57%	9%	18%
Manufacturing	<1*	14*	68*	5	12
Transportation/Communications/ Utilities	1	21	65	5	8
Wholesale	<1*	11*	61	7	21
Retail	2	13	63	11	10
Finance	1	28	52	3*	16
Service	1	21	56	8	14
State/Local Government	1	17	57	17	8
Health Care	2	27	50*	9	13
<b>ALL FIRMS</b>	<b>1%</b>	<b>19%</b>	<b>58%</b>	<b>8%</b>	<b>13%</b>

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different within plan type from estimate for all other firms not in the indicated size, region, or industry category (p<.05).

EMPLOYER HEALTH BENEFITS  
2010 ANNUAL SURVEY

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Worker and  
Employer  
Contributions  
for Premiums

---

SECTION

6

## WORKER AND EMPLOYER CONTRIBUTIONS FOR PREMIUMS

PREMIUM CONTRIBUTIONS BY COVERED WORKERS AVERAGED 19% FOR SINGLE COVERAGE AND 30% FOR FAMILY COVERAGE, A SIGNIFICANT INCREASE FROM THE PERCENTAGES REPORTED IN 2009 FOR BOTH SINGLE AND FAMILY COVERAGE.<sup>1</sup> THE AVERAGE MONTHLY WORKER CONTRIBUTIONS ARE \$75 FOR SINGLE COVERAGE AND \$333 FOR FAMILY COVERAGE.

- ▶ In 2010, covered workers on average contribute 19% of the premium for single coverage, a significant increase from 17% in 2009, and 30% of the premium for family coverage, up from 27% in 2009 (Exhibit 6.1). This is the first statistically significant increase since Kaiser/HRET began the survey in 1999.
- ▶ The average monthly worker contributions increased for both single and family coverage in 2010.
  - On average, workers with single coverage contribute \$75 per month and workers with family coverage contribute \$333 per month towards their health insurance premiums; the amounts are higher than the \$65 and \$293 reported in 2009 (Exhibit 6.2).
  - Workers enrolled in HDHP/SOs contribute a lower amount annually than the overall average worker contribution for single coverage (\$632 compared to \$899), while workers in HMO plans with single coverage contribute a higher amount annually (\$1,028). Workers enrolled in POS plans contribute a larger amount annually (\$5,195) than the overall average worker contribution for family coverage (\$3,997) (Exhibit 6.5).
- ▶ Workers in small firms (3–199 workers) contribute an annual amount of \$865 for single coverage, which is similar to the \$917 contributed by workers in large firms (200 or more workers) (Exhibit 6.8). In contrast, workers in small firms with family coverage contribute significantly more annually than workers with family coverage in large firms, (\$4,665 vs. \$3,652) (Exhibit 6.8).
- From 2009 to 2010, the average annual worker contribution increased significantly for covered workers in small firms (3–199 workers) with single coverage (from \$625 to \$865) (Exhibit 6.6). For family coverage, the average annual worker contribution increased from 2009 to 2010 for workers in large firms (200 or more workers) (from \$3,182 to \$3,652) (Exhibit 6.7). The average annual worker contribution remained stable from 2009 to 2010 for covered workers with single coverage in large firms and family coverage in small firms (Exhibits 6.6 and 6.7).
- ▶ There is a great deal of variation in worker contributions.
  - Thirty-four percent of covered workers contribute at least \$1,079 annually (120% of the average worker contribution) for single coverage, while 42% of covered workers have an annual worker contribution of less than \$719 (80% of the average worker contribution) (Exhibit 6.14).
  - For family coverage, 28% of covered workers contribute at least \$4,797 annually (120% of the average worker contribution), while 46% of covered workers have an annual worker contribution of less than \$3,198 (80% of the average worker contribution) (Exhibit 6.14).
- ▶ The majority of covered workers are employed by a firm that contributes at least half of the premium.
  - Sixteen percent of workers with single coverage and 5% of workers with family coverage work for a firm that pays 100% of the premium (Exhibit 6.15).

### NOTE:

<sup>1</sup> Estimates for premiums, worker contributions to premiums, and employer contributions to premiums presented in Section 6 do not include contributions made by the employer to Health Savings Accounts or Health Reimbursement Arrangements. See Section 8 for estimates of employer contributions to HSAs and HRAs.

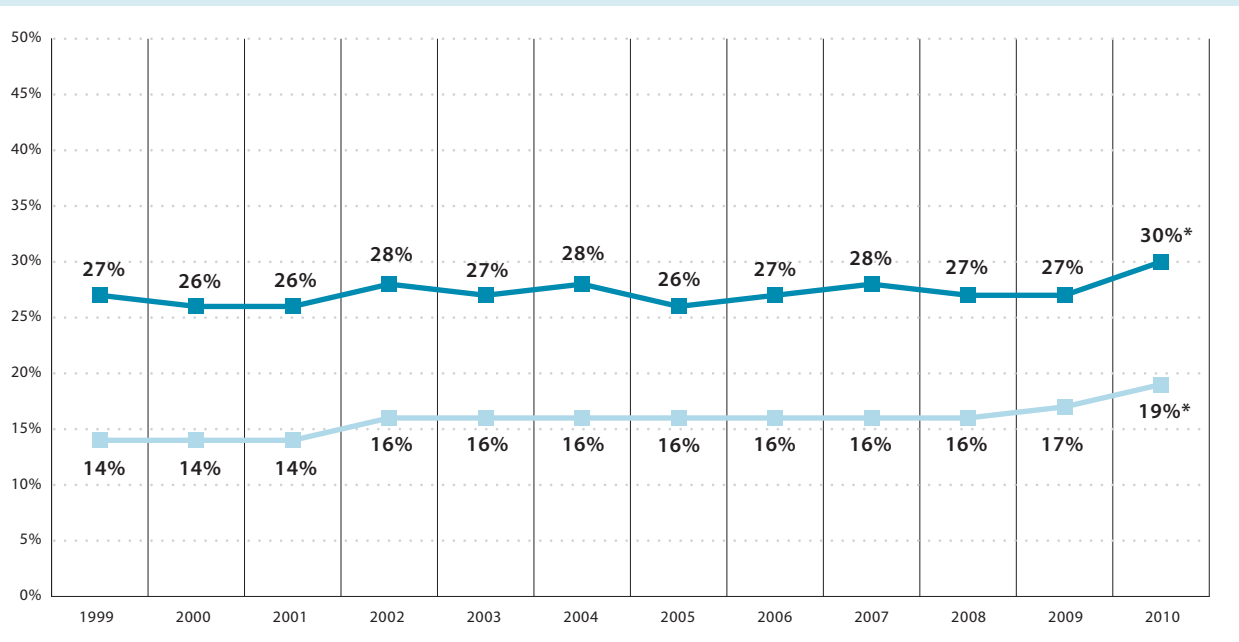
- Covered workers in small firms (3–199 workers) are more likely to work for a firm that pays 100% of the premium than workers in large firms (200 or more workers). Thirty-five percent of covered workers in small firms have an employer that pays the full premium for single coverage, compared to 6% of covered workers in large firms (Exhibit 6.16). For family coverage, 13% percent of covered workers in small firms have an employer that pays the full premium for family coverage, compared to 1% of covered workers in large firms (Exhibit 6.17).
- Eight percent of covered workers in small firms (3–199 workers) contribute more than 50% of the premium for single coverage, compared to 1% of covered workers in large firms (200 or more workers) (Exhibit 6.16). For family coverage, 32% of covered workers in small firms work in a firm where they must contribute more than 50% of the premium, compared to 8% of covered workers in large firms (Exhibit 6.17).
- ▶ The percentage of the premium paid by covered workers varies by several firm characteristics.
  - For single coverage, workers in firms with many lower-wage workers (where 35% or more earn \$23,000 a year or less) contribute a greater percentage of the premium than those in firms with fewer lower-wage workers (where less than 35% earn \$23,000 a year or less) (24% vs. 18%) (Exhibit 6.19).
  - For family coverage, workers in firms with many lower-wage workers (35% or more earn \$23,000 or less annually) contribute a greater percentage of the premium than those in firms with fewer lower-wage workers (less than 35% earn \$23,000 or less annually) (35% vs. 29%) (Exhibit 6.20).
  - Workers with family coverage in firms that are partially or completely self-funded contribute a significantly lower percentage of the premium than those in firms that are fully insured (26% vs. 36%).<sup>2</sup> Among small firms, contributions for workers in self-insured plans are 27% compared to 38% for fully insured plans. For large firms, the contributions are 25% and 32% (Exhibit 6.20).
  - Workers with family coverage in firms that have at least some union workers contribute a significantly lower percentage of the premium than those in firms without any union workers (24% vs. 33%) (Exhibit 6.20).
- ▶ Some workers are employed by firms that vary premium contributions by workers' wages.
  - Thirteen percent of covered workers are in firms that vary worker premium contributions by wage level, which is statistically unchanged from the 10% reported in 2008, which was the last time the question was asked. Workers in large firms are more likely to be employed by a firm that varies contributions by wage than workers in small firms (17% vs. 6%) (Exhibit 6.25).

## NOTE:

<sup>2</sup> For definitions of Self-Funded and Fully Insured plans, see the introduction to Section 10.

EXHIBIT 6.1

Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, 1999–2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

FAMILY COVERAGE  
SINGLE COVERAGE

EXHIBIT 6.2

Average Monthly Worker Premium Contributions Paid by Covered Workers for Single and Family Coverage, 1999–2010



SOURCE:

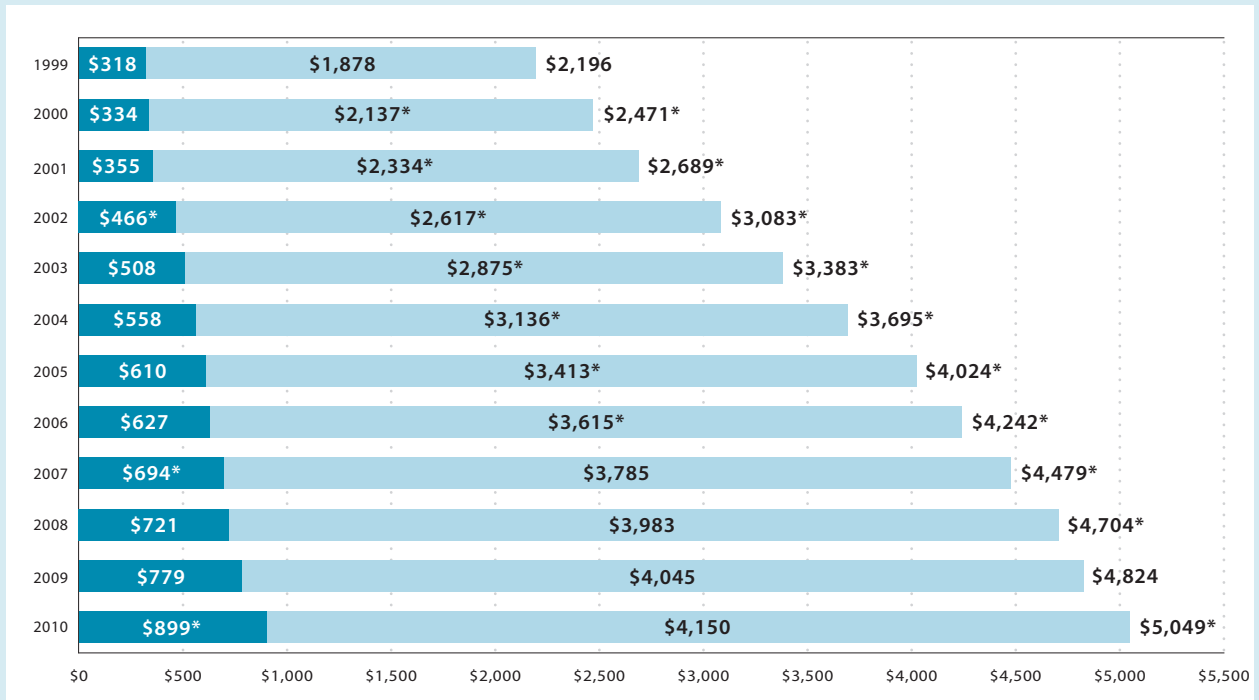
Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

FAMILY COVERAGE  
SINGLE COVERAGE

EXHIBIT 6.3

Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Single Coverage, 1999–2010



SOURCE:

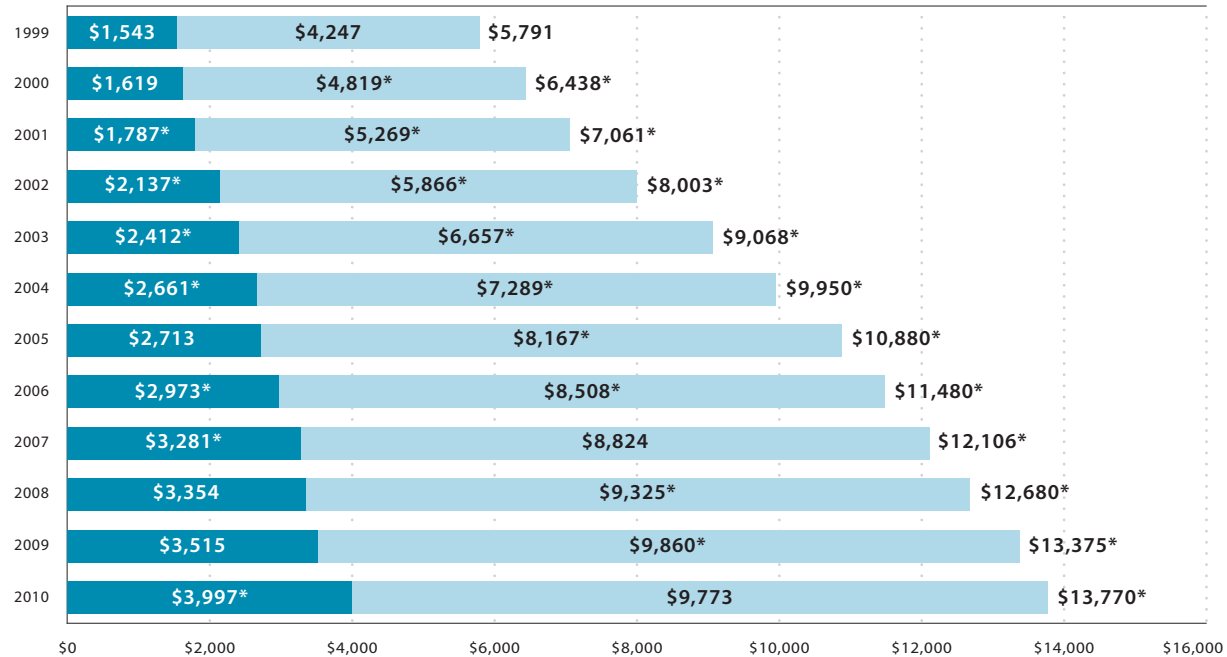
Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

WORKER CONTRIBUTION  
EMPLOYER CONTRIBUTION

EXHIBIT 6.4

Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999–2010



SOURCE:

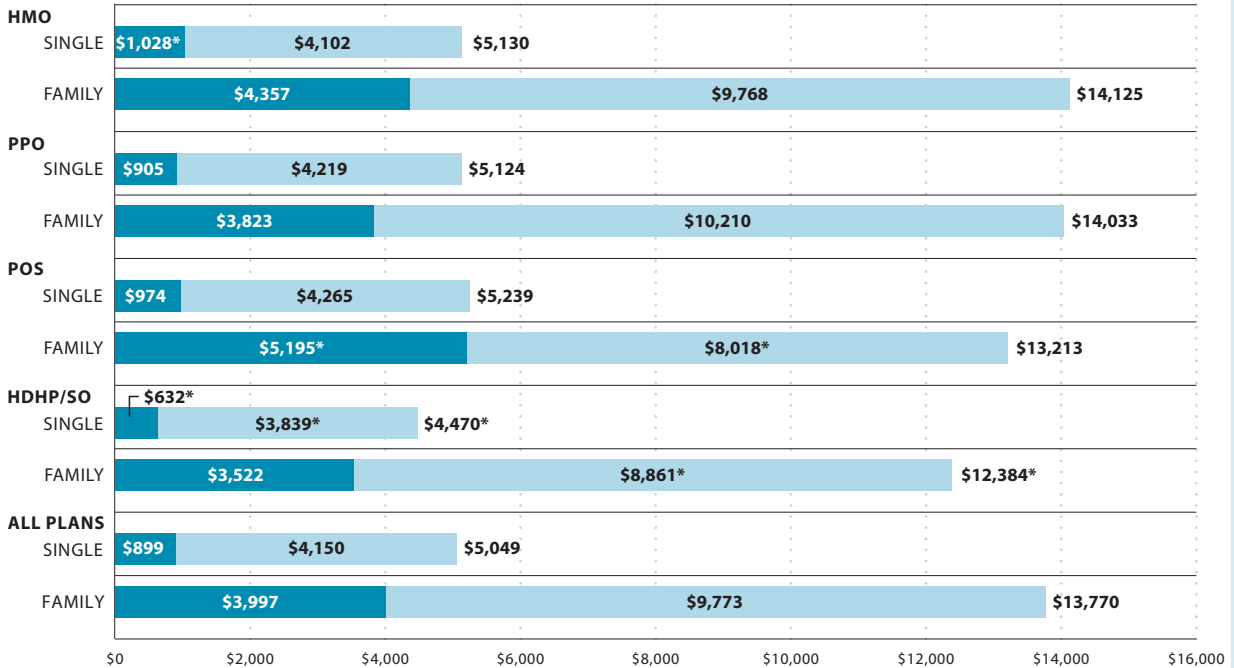
Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

WORKER CONTRIBUTION  
EMPLOYER CONTRIBUTION

EXHIBIT 6.5

Average Annual Firm and Worker Premium Contributions and Total Premiums for Covered Workers for Single and Family Coverage, by Plan Type, 2010



SOURCE:

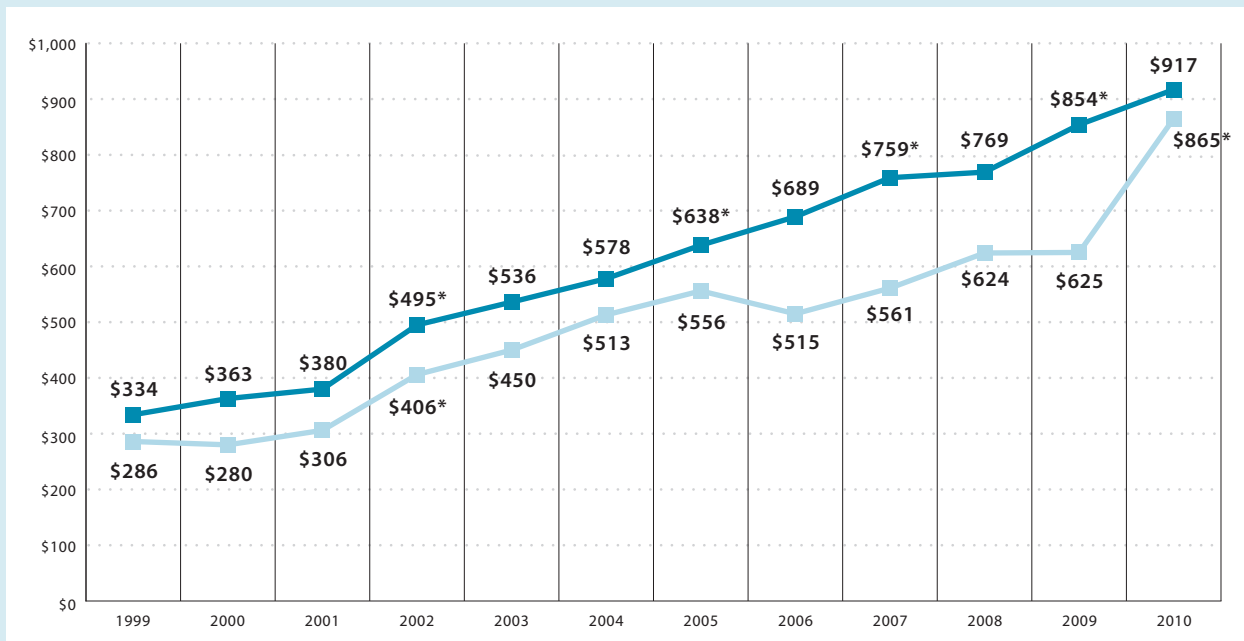
Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

WORKER CONTRIBUTION  
EMPLOYER CONTRIBUTION

\* Estimate is statistically different from All Plans estimate by coverage type ( $p < .05$ ).

EXHIBIT 6.6

Average Annual Worker Contributions for Covered Workers with Single Coverage, by Firm Size, 1999–2010



SOURCE:

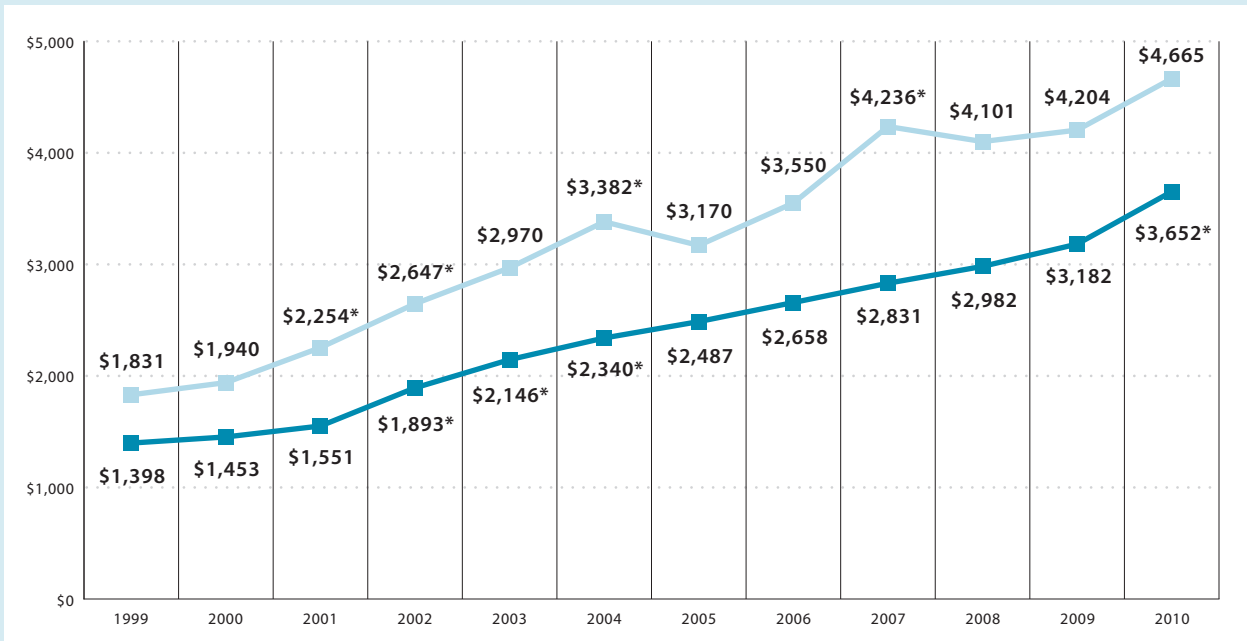
Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

— ALL SMALL FIRMS  
(3–199 WORKERS)  
— ALL LARGE FIRMS  
(200 OR MORE WORKERS)

EXHIBIT 6.7

Average Annual Worker Contributions for Covered Workers with Family Coverage, by Firm Size, 1999–2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

— ALL SMALL FIRMS  
(3–199 WORKERS)  
— ALL LARGE FIRMS  
(200 OR MORE WORKERS)

## EXHIBIT 6.8

## Average Annual Worker Premium Contributions Paid by Covered Workers for Single and Family Coverage, by Firm Size, 1999–2010

	Single Coverage		Family Coverage	
	All Small Firms (3–199 Workers)	All Large Firms (200 or More Workers)	All Small Firms (3–199 Workers)	All Large Firms (200 or More Workers)
1999	\$286	\$334	\$1,831*	\$1,398*
2000	\$280*	\$363*	\$1,940*	\$1,453*
2001	\$306*	\$380*	\$2,254*	\$1,551*
2002	\$406*	\$495*	\$2,647*	\$1,893*
2003	\$450	\$536	\$2,970*	\$2,146*
2004	\$513	\$578	\$3,382*	\$2,340*
2005	\$556	\$638	\$3,170*	\$2,487*
2006	\$515*	\$689*	\$3,550*	\$2,658*
2007	\$561*	\$759*	\$4,236*	\$2,831*
2008	\$624*	\$769*	\$4,101*	\$2,982*
2009	\$625*	\$854*	\$4,204*	\$3,182*
2010	\$865	\$917	\$4,665*	\$3,652*

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Estimate is statistically different between All Small Firms and All Large Firms within year ( $p < .05$ ).

EXHIBIT 6.9

Average Annual Firm and Worker Premium Contributions and Total Premiums for Covered Workers for Single Coverage, by Plan Type and Firm Size, 2010

	Worker Contribution	Employer Contribution	Total Premium
<b>HMO</b>			
All Small Firms (3–199 Workers)	\$991	\$4,141	\$5,133
All Large Firms (200 or More Workers)	\$1,045	\$4,085	\$5,129
<b>PPO</b>			
All Small Firms (3–199 Workers)	\$787*	\$4,382	\$5,169
All Large Firms (200 or More Workers)	\$956*	\$4,148	\$5,104
<b>POS</b>			
All Small Firms (3–199 Workers)	\$1,145	\$4,000	\$5,145
All Large Firms (200 or More Workers)	\$676	\$4,725	\$5,402
<b>HDHP/SO</b>			
All Small Firms (3–199 Workers)	\$716	\$3,738	\$4,454
All Large Firms (200 or More Workers)	\$571	\$3,911	\$4,482
<b>ALL PLANS</b>			
All Small Firms (3–199 Workers)	\$865	\$4,180	\$5,046
All Large Firms (200 or More Workers)	\$917	\$4,133	\$5,050

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimates are statistically different within plan type between All Small Firms and All Large Firms ( $p < .05$ ).

## EXHIBIT 6.10

Average Annual Firm and Worker Premium Contributions and Total Premiums for Covered Workers for Family Coverage, by Plan Type and Firm Size, 2010

	Worker Contribution	Employer Contribution	Total Premium
<b>HMO</b>			
All Small Firms (3–199 Workers)	\$4,972	\$8,313*	\$13,285*
All Large Firms (200 or More Workers)	\$4,089	\$10,403*	\$14,492*
<b>PPO</b>			
All Small Firms (3–199 Workers)	\$4,380*	\$9,355*	\$13,735
All Large Firms (200 or More Workers)	\$3,586*	\$10,574*	\$14,161
<b>POS</b>			
All Small Firms (3–199 Workers)	\$5,536	\$7,289	\$12,825
All Large Firms (200 or More Workers)	\$4,634	\$9,216	\$13,850
<b>HDHP/SO</b>			
All Small Firms (3–199 Workers)	\$4,472*	\$7,550*	\$12,022
All Large Firms (200 or More Workers)	\$2,849*	\$9,791*	\$12,640
<b>ALL PLANS</b>			
All Small Firms (3–199 Workers)	\$4,665*	\$8,585*	\$13,250*
All Large Firms (200 or More Workers)	\$3,652*	\$10,386*	\$14,038*

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimates are statistically different within plan type between All Small Firms and All Large Firms ( $p < .05$ ).

EXHIBIT 6.11

Average Monthly and Annual Worker Premium Contributions Paid by Covered Workers for Single and Family Coverage, by Plan Type and Firm Size, 2010

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
<b>HMO</b>				
All Small Firms (3–199 Workers)	\$83	\$414	\$991	\$4,972
All Large Firms (200 or More Workers)	87	341	1,045	4,089
<b>ALL FIRM SIZES</b>	<b>\$86</b>	<b>\$363</b>	<b>\$1,028</b>	<b>\$4,357</b>
<b>PPO</b>				
All Small Firms (3–199 Workers)	\$66*	\$365*	\$787*	\$4,380*
All Large Firms (200 or More Workers)	80*	299*	956*	3,586*
<b>ALL FIRM SIZES</b>	<b>\$75</b>	<b>\$319</b>	<b>\$905</b>	<b>\$3,823</b>
<b>POS</b>				
All Small Firms (3–199 Workers)	\$95	\$461	\$1,145	\$5,536
All Large Firms (200 or More Workers)	56	386	676	4,634
<b>ALL FIRM SIZES</b>	<b>\$81</b>	<b>\$433</b>	<b>\$974</b>	<b>\$5,195</b>
<b>HDHP/SO</b>				
All Small Firms (3–199 Workers)	\$60	\$373*	\$716	\$4,472*
All Large Firms (200 or More Workers)	48	237*	571	2,849*
<b>ALL FIRM SIZES</b>	<b>\$53</b>	<b>\$294</b>	<b>\$632</b>	<b>\$3,522</b>
<b>ALL PLANS</b>				
All Small Firms (3–199 Workers)	\$72	\$389*	\$865	\$4,665*
All Large Firms (200 or More Workers)	76	304*	917	3,652*
<b>ALL FIRM SIZES</b>	<b>\$75</b>	<b>\$333</b>	<b>\$899</b>	<b>\$3,997</b>

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimates are statistically different within plan type between All Small Firms and All Large Firms ( $p < .05$ ).

## EXHIBIT 6.12

Average Monthly and Annual Worker Premium Contributions Paid by Covered Workers for Single and Family Coverage, by Plan Type and Region, 2010

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
<b>HMO</b>				
Northeast	\$111*	\$339	\$1,333*	\$4,069
Midwest	76	345	908	4,145
South	77	340	929	4,082
West	76	401	916	4,809
<b>ALL REGIONS</b>	<b>\$86</b>	<b>\$363</b>	<b>\$1,028</b>	<b>\$4,357</b>
<b>PPO</b>				
Northeast	\$83	\$282*	\$998	\$3,388*
Midwest	79	326	947	3,916
South	71	348*	848	4,177*
West	73	280	882	3,359
<b>ALL REGIONS</b>	<b>\$75</b>	<b>\$319</b>	<b>\$905</b>	<b>\$3,823</b>
<b>POS</b>				
Northeast	\$167	\$375	\$2,000	\$4,495
Midwest	67	394	808	4,733
South	52	443	628	5,317
West	76	484	907	5,813
<b>ALL REGIONS</b>	<b>\$81</b>	<b>\$433</b>	<b>\$974</b>	<b>\$5,195</b>
<b>HDHP/SO</b>				
Northeast	\$59	\$357	\$707	\$4,278
Midwest	55	230*	658	2,765*
South	59	363	710	4,358
West	32*	242	382*	2,903
<b>ALL REGIONS</b>	<b>\$53</b>	<b>\$294</b>	<b>\$632</b>	<b>\$3,522</b>
<b>ALL PLANS</b>				
Northeast	\$94*	\$313	\$1,123*	\$3,754
Midwest	73	313	876	3,759
South	68*	358*	822*	4,300*
West	70	331	841	3,978
<b>ALL REGIONS</b>	<b>\$75</b>	<b>\$333</b>	<b>\$899</b>	<b>\$3,997</b>

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different within plan type from estimate for all other firms not in the indicated region (p<.05).

EXHIBIT 6.13

Average Monthly Worker Premium Contributions Paid by Covered Workers for Single and Family Coverage, by Plan Type, 1999–2010

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
<b>Single Coverage</b>												
HMO	\$28	\$26	\$32	\$38	\$42	\$46	\$47	\$49	\$59	\$59	\$68	\$86*
PPO	27	29	29	39*	44	48	50	53	60*	61	67*	75*
POS	27	28	29	40*	41	45	61*	53	52	72	62	81
HDHP/SO	^	^	^	^	^	^	^	47	43	39	45	53
<b>ALL PLANS</b>	<b>\$27</b>	<b>\$28</b>	<b>\$30</b>	<b>\$39*</b>	<b>\$42</b>	<b>\$47</b>	<b>\$51</b>	<b>\$52</b>	<b>\$58*</b>	<b>\$60</b>	<b>\$65</b>	<b>\$75*</b>
<b>Family Coverage</b>												
HMO	\$124	\$131	\$150	\$164	\$179	\$223*	\$217	\$257*	\$276	\$282	\$307	\$363*
PPO	128	141	153	188*	210*	224	220	243*	270*	279	289	319*
POS	141	136	143	180*	206	218	271*	269	305	311	346	433*
HDHP/SO	^	^	^	^	^	^	^	187	238	234	223	294*
<b>ALL PLANS</b>	<b>\$129</b>	<b>\$135</b>	<b>\$149*</b>	<b>\$178*</b>	<b>\$201*</b>	<b>\$222*</b>	<b>\$226</b>	<b>\$248*</b>	<b>\$273*</b>	<b>\$280</b>	<b>\$293</b>	<b>\$333*</b>

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2010.

\* Estimate is statistically different from estimate for the previous year shown (p<.05).

^ Information was not obtained for HDHP/SOs prior to 2006.

EXHIBIT 6.14

Distribution of Worker Premium Contributions for Single and Family Coverage Relative to the Average Annual Worker Premium Contribution, 2010

Premium Contribution Range, Relative to Average Premium Contribution	Single Coverage		Family Coverage	
	Premium Contribution Range, Dollar Amount	Percentage of Covered Workers in Range	Premium Contribution Range, Dollar Amount	Percentage of Covered Workers in Range
Less than 80%	Less than \$719	42%	Less than \$3,198	46%
80% to Less Than Average	\$719 to <\$899	12%	\$3,198 to <\$3,997	16%
Average to Less Than 120%	\$899 to <\$1,079	12%	\$3,997 to <\$4,797	11%
120% or More	\$1,079 or More	34%	\$4,797 or More	28%

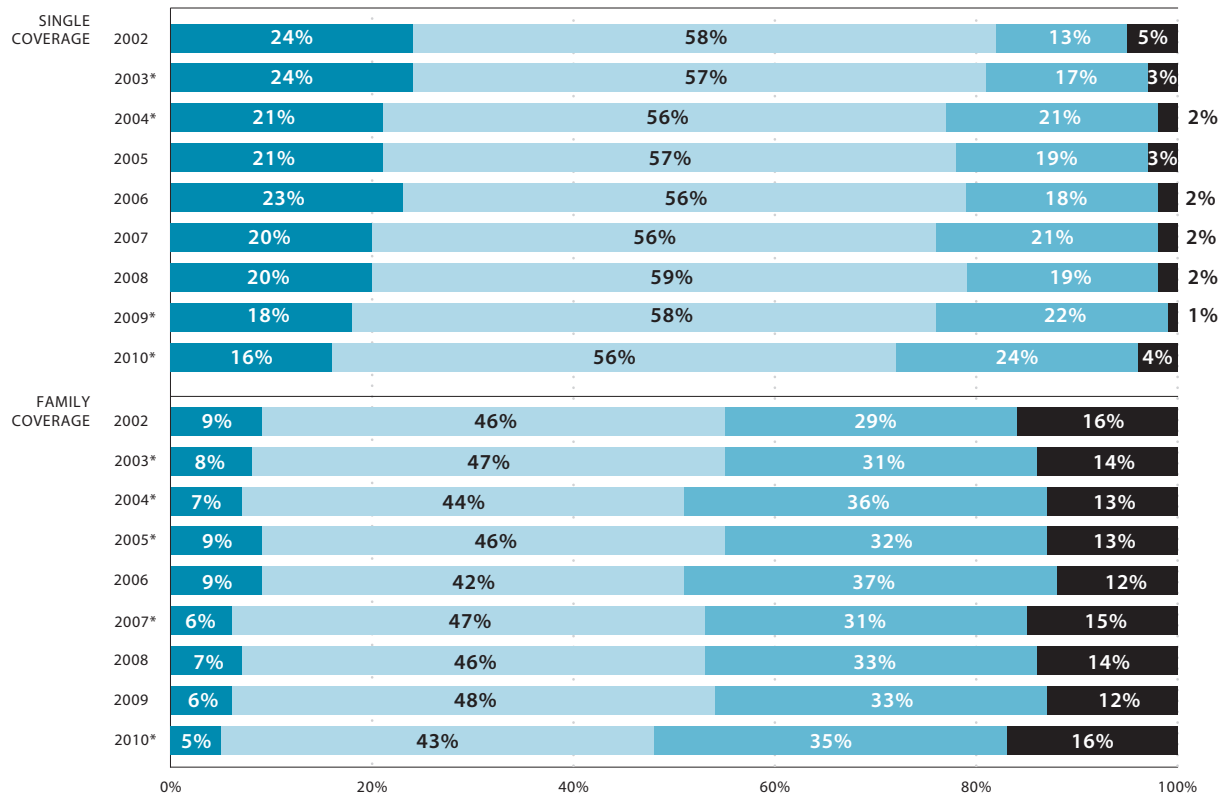
SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

Note: The average annual worker contribution is \$899 for single coverage and \$3,997 for family coverage. The worker contribution distribution is relative to the average single or family worker contribution. For example, \$719 is 80% of the average single worker contribution and \$1,079 is 120% of the average single worker contribution. The same break points relative to the average are used for the distribution for family coverage.

EXHIBIT 6.15

Distribution of Percentage of Premium Paid by Covered Workers for Single and Family Coverage, 2002–2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002–2010.

\* Distribution is statistically different within coverage type from distribution for the previous year shown ( $p < .05$ ).

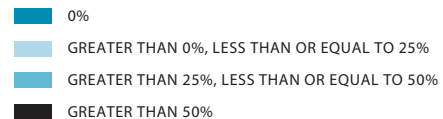
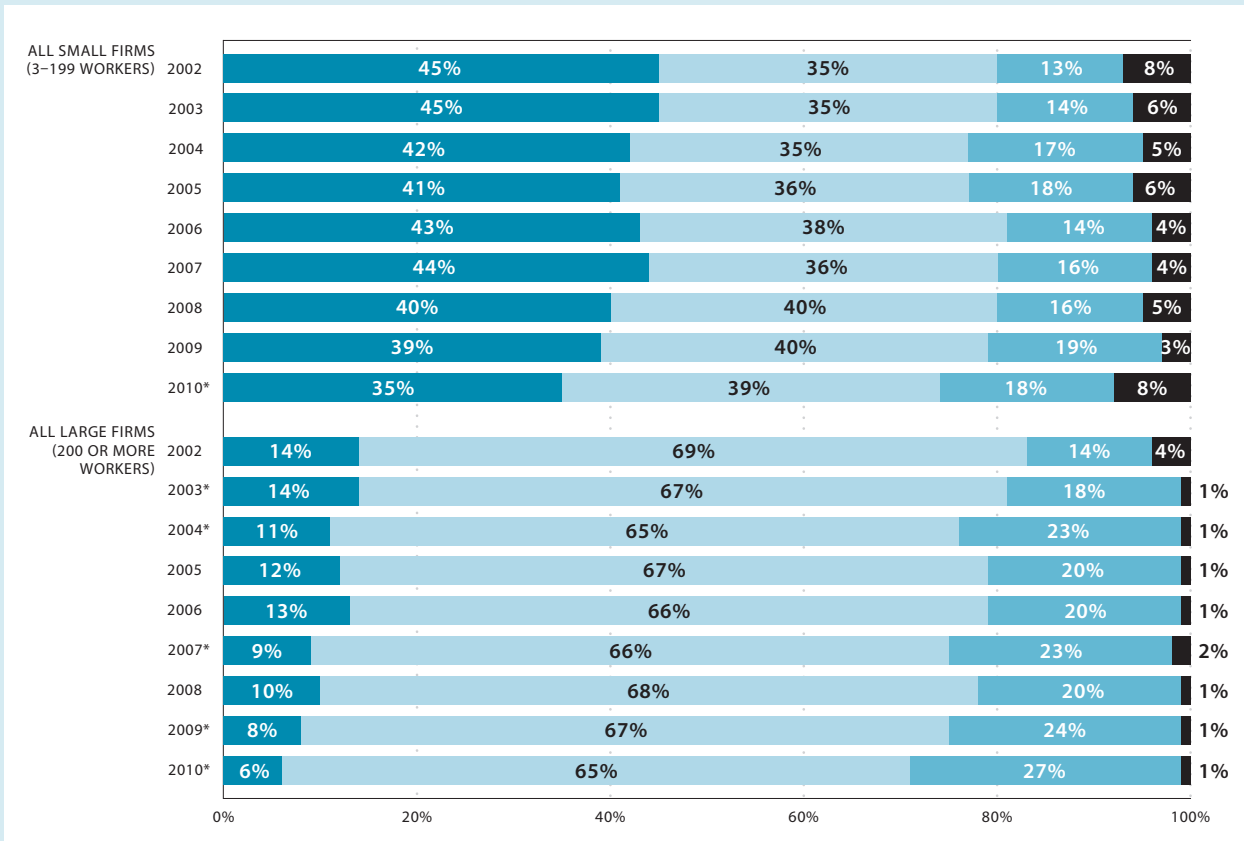


EXHIBIT 6.16

Distribution of Percentage of Premium Paid by Covered Workers for Single Coverage, by Firm Size, 2002–2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002–2010.

\* Distribution is statistically different within size category from distribution for the previous year shown ( $p < .05$ ).

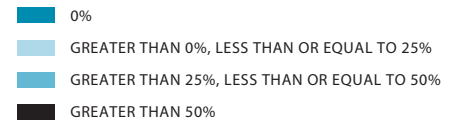
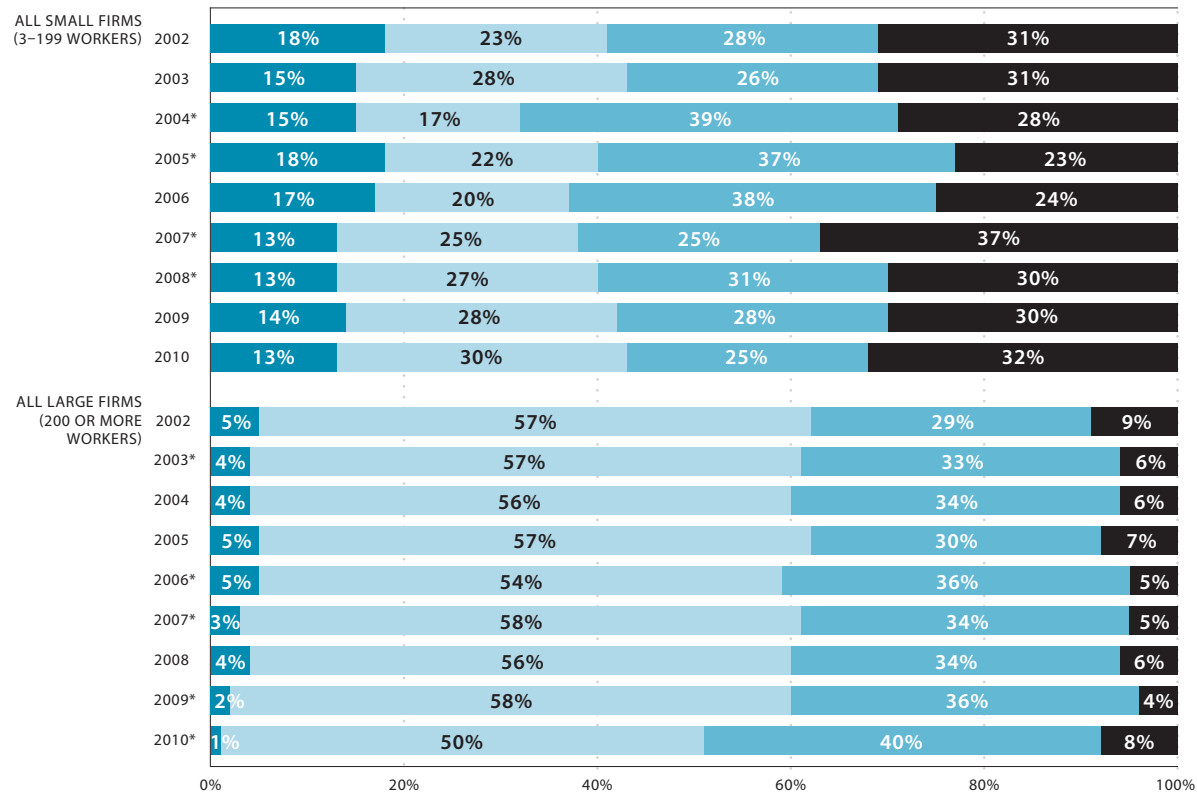


EXHIBIT 6.17

Distribution of Percentage of Premium Paid by Covered Workers for Family Coverage, by Firm Size, 2002–2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002–2010.

\* Distribution is statistically different within size category from distribution for the previous year shown ( $p < .05$ ).

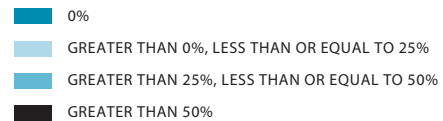
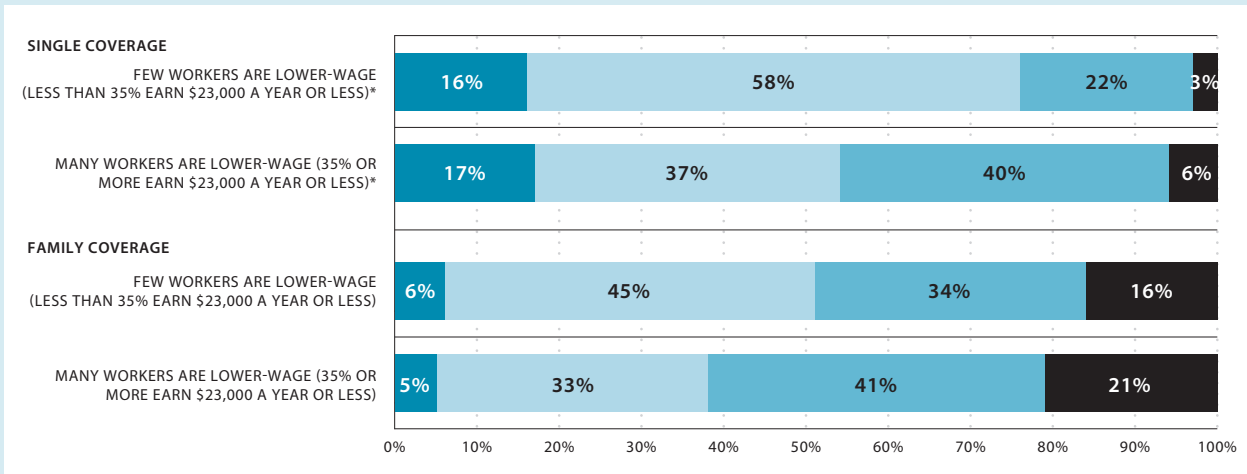


EXHIBIT 6.18

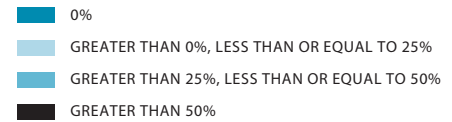
Distribution of the Percentage of Total Premium Paid by Covered Workers for Single and Family Coverage, by Wage, 2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Distributions for Higher-Wage and Lower-Wage Firms are statistically different ( $p < .05$ ).



## EXHIBIT 6.19

## Average Percentage of Premium Paid by Covered Workers for Single Coverage, by Firm Characteristics, 2010

	All Small Firms (3–199 Workers)	All Large Firms (200 or More Workers)	All Firms
<b>Wage Level</b>			
Few Workers Are Lower-Wage (Less Than 35% Earn \$23,000 a Year or Less)	17%	18%*	18%*
Many Workers Are Lower-Wage (35% or More Earn \$23,000 a Year or Less)	19%	26%*	24%*
<b>Unions</b>			
Firm Has At Least Some Union Workers	17%	17%*	17%
Firm Does Not Have Any Union Workers	18%	21%*	19%
<b>Younger Workers</b>			
Less Than 35% of Workers Are Age 26 or Younger	17%	19%	18%
35% or More Workers Are Age 26 or Younger	24%	22%	22%
<b>Older Workers</b>			
Less Than 35% of Workers Are Age 50 or Older	19%	19%	19%
35% or More Workers Are Age 50 or Older	15%	18%	17%
<b>Funding Arrangement</b>			
Fully Insured	18%	20%	18%
Self-Funded	17%	19%	19%

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimates are statistically different from each other within firm size category ( $p < .05$ ).

EXHIBIT 6.20

Average Percentage of Premium Paid by Covered Workers for Family Coverage, by Firm Characteristics, 2010

	All Small Firms (3–199 Workers)	All Large Firms (200 or More Workers)	All Firms
<b>Wage Level</b>			
Few Workers Are Lower-Wage (Less Than 35% Earn \$23,000 a Year or Less)	36%	26%*	29%*
Many Workers Are Lower-Wage (35% or More Earn \$23,000 a Year or Less)	38%	33%*	35%*
<b>Unions</b>			
Firm Has At Least Some Union Workers	26%*	23%*	24%*
Firm Does Not Have Any Union Workers	37%*	29%*	33%*
<b>Younger Workers</b>			
Less Than 35% of Workers Are Age 26 or Younger	35%	26%	29%
35% or More Workers Are Age 26 or Younger	46%	31%	35%
<b>Older Workers</b>			
Less Than 35% of Workers Are Age 50 or Older	37%	26%	30%
35% or More Workers Are Age 50 or Older	33%	28%	30%
<b>Funding Arrangement</b>			
Fully Insured	38%*	32%*	36%*
Self-Funded	27%*	25%*	26%*

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimates are statistically different from each other within firm size category ( $p < .05$ ).

## EXHIBIT 6.21

Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Plan Type and Firm Size, 2010

	Single Coverage	Family Coverage
<b>HMO</b>		
All Small Firms (3–199 Workers)	20%	37%*
All Large Firms (200 or More Workers)	21	29*
<b>ALL FIRM SIZES</b>	<b>21%</b>	<b>31%</b>
<b>PPO</b>		
All Small Firms (3–199 Workers)	16%*	33%*
All Large Firms (200 or More Workers)	20*	26*
<b>ALL FIRM SIZES</b>	<b>19%</b>	<b>28%</b>
<b>POS</b>		
All Small Firms (3–199 Workers)	23%	42%
All Large Firms (200 or More Workers)	12	35
<b>ALL FIRM SIZES</b>	<b>19%</b>	<b>39%</b>
<b>HDHP/SO</b>		
All Small Firms (3–199 Workers)	15%	37%*
All Large Firms (200 or More Workers)	14	22*
<b>ALL FIRM SIZES</b>	<b>14%</b>	<b>28%</b>
<b>ALL PLANS</b>		
All Small Firms (3–199 Workers)	18%	36%*
All Large Firms (200 or More Workers)	19	27*
<b>ALL FIRM SIZES</b>	<b>19%</b>	<b>30%</b>

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimates are statistically different within plan type between All Small Firms and All Large Firms ( $p < .05$ ).

EXHIBIT 6.22

Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Plan Type, 1999–2010

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
<b>Single Coverage</b>												
HMO	16%	14%	18%	16%	17%	16%	16%	15%	17%	16%	18%	21%*
PPO	13	14	13	16*	16	16	15	15	17	16	17	19
POS	15	14	13	16*	16	16	19	16	14	18	16	19
HDHP/SO	^	^	^	^	^	^	^	18	15	11	14	14
<b>ALL PLANS</b>	<b>14%</b>	<b>14%</b>	<b>14%</b>	<b>16%</b>	<b>16%</b>	<b>16%</b>	<b>16%</b>	<b>16%</b>	<b>16%</b>	<b>16%</b>	<b>17%</b>	<b>19%*</b>
<b>Family Coverage</b>												
HMO	28%	26%	29%	27%	26%	29%	26%	28%	28%	26%	28%	31%
PPO	26	27	26	29*	28	27	25	26	27	27	26	28
POS	28	26	25	28	28	28	31	30	32	31	32	39
HDHP/SO	^	^	^	^	^	^	^	25	27	29	25	28
<b>ALL PLANS</b>	<b>27%</b>	<b>26%</b>	<b>26%</b>	<b>28%</b>	<b>27%</b>	<b>28%</b>	<b>26%</b>	<b>27%</b>	<b>28%</b>	<b>27%</b>	<b>27%</b>	<b>30%*</b>

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

^ Information was not obtained for HDHP/SOs prior to 2006.

## EXHIBIT 6.23

Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Plan Type and Region, 2010

	Single Coverage	Family Coverage
<b>HMO</b>		
Northeast	23%	27%*
Midwest	19	30
South	20	31
West	20	35
<b>ALL REGIONS</b>	<b>21%</b>	<b>31%</b>
<b>PPO</b>		
Northeast	19%	24%*
Midwest	19	27
South	19	33*
West	17	24*
<b>ALL REGIONS</b>	<b>19%</b>	<b>28%</b>
<b>POS</b>		
Northeast	33%	29%*
Midwest	16	30
South	14	42
West	19	49
<b>ALL REGIONS</b>	<b>19%</b>	<b>39%</b>
<b>HDHP/SO</b>		
Northeast	15%	31%
Midwest	16	23*
South	15	36*
West	9*	25
<b>ALL REGIONS</b>	<b>14%</b>	<b>28%</b>
<b>ALL PLANS</b>		
Northeast	21%	26%*
Midwest	18	27*
South	18	34*
West	17	30
<b>ALL REGIONS</b>	<b>19%</b>	<b>30%</b>

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different within plan type from estimate for all other firms not in the indicated region ( $p < .05$ ).

EXHIBIT 6.24

Average Percentage of Premium Paid by Covered Workers, by Plan Type and Industry, 2010

	Single Coverage	Family Coverage
<b>HMO</b>		
Agriculture/Mining/Construction	NSD	NSD
Manufacturing	25%	24%*
Transportation/Communications/Utilities	18	23*
Wholesale	NSD	NSD
Retail	NSD	NSD
Finance	20	28
Service	22	36*
State/Local Government	12*	20*
Health Care	20	35
<b>ALL INDUSTRIES</b>	<b>21%</b>	<b>31%</b>
<b>PPO</b>		
Agriculture/Mining/Construction	21%	32%
Manufacturing	22*	26
Transportation/Communications/Utilities	19	28
Wholesale	20	29
Retail	22	38
Finance	22*	27
Service	18	31
State/Local Government	10*	21*
Health Care	16	29
<b>ALL INDUSTRIES</b>	<b>19%</b>	<b>28%</b>
<b>POS</b>		
Agriculture/Mining/Construction	NSD	NSD
Manufacturing	NSD	NSD
Transportation/Communications/Utilities	NSD	NSD
Wholesale	NSD	NSD
Retail	NSD	NSD
Finance	NSD	NSD
Service	14%	31%*
State/Local Government	NSD	NSD
Health Care	NSD	NSD
<b>ALL INDUSTRIES</b>	<b>19%</b>	<b>39%</b>

Continued on next page

**EXHIBIT 6.24** *Continued from previous page*

## Average Percentage of Premium Paid by Covered Workers, by Plan Type and Industry, 2010

	Single Coverage	Family Coverage
<b>HDHP/SO</b>		
Agriculture/Mining/Construction	NSD	NSD
Manufacturing	17%	25%
Transportation/Communications/Utilities	18	26
Wholesale	15	22
Retail	NSD	NSD
Finance	12	29
Service	10*	25
State/Local Government	NSD	NSD
Health Care	16	25
<b>ALL INDUSTRIES</b>	<b>14%</b>	<b>28%</b>
<b>ALL PLANS</b>		
Agriculture/Mining/Construction	18%	33%
Manufacturing	22*	26*
Transportation/Communications/Utilities	19	26
Wholesale	19	28
Retail	25	34
Finance	19	28
Service	17	31
State/Local Government	9*	25
Health Care	19	32
<b>ALL INDUSTRIES</b>	<b>19%</b>	<b>30%</b>

**SOURCE:**

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different within plan type from estimate for all other firms not in the indicated industry ( $p < .05$ ).

NSD: Not Sufficient Data.

EXHIBIT 6.25

Percentage of Covered Workers in Firms That Vary Worker Premium Contributions by Wage, by Firm Size and Region, 2010

	Percentage of Covered Workers in Firms That Vary Worker Premium Contributions by Wage Level
<b>FIRM SIZE</b>	
200–999 Workers	9%
1,000–4,999 Workers	16
5,000 or More Workers	21*
<b>All Small Firms (3–199 Workers)</b>	<b>6%*</b>
<b>All Large Firms (200 or More Workers)</b>	<b>17%*</b>
<b>REGION</b>	
Northeast	20%
Midwest	11
South	12
West	13
<b>ALL FIRMS</b>	<b>13%</b>

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different from estimate for all firms not in the indicated size or region category ( $p < .05$ ).

EMPLOYER HEALTH BENEFITS  
2010 ANNUAL SURVEY

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Employee  
Cost Sharing

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SECTION

7

## EMPLOYEE COST SHARING

IN ADDITION TO ANY REQUIRED PREMIUM CONTRIBUTIONS, COVERED WORKERS MAY FACE COST SHARING FOR THE MEDICAL SERVICES THAT THEY USE. COST SHARING FOR MEDICAL SERVICES CAN TAKE A VARIETY OF FORMS, INCLUDING DEDUCTIBLES (AN AMOUNT THAT MUST BE PAID BEFORE SOME OR ALL SERVICES ARE COVERED), COPAYMENTS (FIXED DOLLAR AMOUNTS), AND/OR COINSURANCE (A PERCENTAGE OF THE CHARGE FOR SERVICES). THE TYPE AND LEVEL OF COST SHARING OFTEN VARIES BY THE TYPE OF PLAN IN WHICH THE WORKER IS ENROLLED. COST SHARING MAY ALSO VARY BY THE TYPE OF SERVICE RECEIVED SUCH AS OFFICE VISITS, HOSPITALIZATIONS, OR PRESCRIPTION DRUGS.

THE COST-SHARING AMOUNTS REPORTED HERE ARE FOR COVERED WORKERS USING SERVICES PROVIDED IN-NETWORK BY PARTICIPATING PROVIDERS. PLAN ENROLLEES RECEIVING SERVICES FROM PROVIDERS THAT DO NOT PARTICIPATE IN PLAN NETWORKS OFTEN FACE HIGHER COST SHARING AND MAY BE RESPONSIBLE FOR CHARGES THAT EXCEED PLAN ALLOWABLE AMOUNTS. THE FRAMEWORK OF THIS SURVEY DOES NOT ALLOW US TO CAPTURE ALL OF THE COMPLEX COST-SHARING REQUIREMENTS IN MODERN PLANS, PARTICULARLY FOR ANCILLARY SERVICES (SUCH AS DURABLE MEDICAL EQUIPMENT OR PHYSICAL THERAPY) OR COST-SHARING ARRANGEMENTS THAT VARY ACROSS DIFFERENT SETTINGS (SUCH AS TIERED NETWORKS). THEREFORE, WE DO NOT COLLECT INFORMATION ON ALL OF THE PLAN PROVISIONS AND LIMITS THAT AFFECT ENROLLEE OUT-OF-POCKET LIABILITY.

### GENERAL ANNUAL DEDUCTIBLES

- ▶ A general annual deductible is an amount that must be paid by the enrollee before all or most services are covered by their health plan. The likelihood of having a deductible varies by plan type.
  - Workers in HMOs are least likely to have a general annual deductible for single coverage compared to other plan types. Seventy-two percent of workers in HMOs with single coverage do not have a general annual deductible, compared to 34% of workers in POS plans and 23% of workers in PPOs. The percentages are similar for family coverage (Exhibit 7.1). Between 2009 and 2010 the percentage of workers in HMOs without a deductible for single or family coverage decreased from 84% to 72%.
  - Workers without a general annual plan deductible often have other forms of cost sharing for medical services. For workers without a general annual deductible for single coverage, 78% of workers in HMOs, 75% of workers in PPOs, and 74% of workers in POS plans are
- in plans that require cost sharing for hospital admissions. The percentages are similar for family coverage (Exhibit 7.2).
- ▶ Deductibles vary greatly by plan type and firm size.
  - The average annual deductibles among those workers with a deductible for single coverage are \$601 for HMOs, \$675 for PPOs, \$1,048 for POS plans, and \$1,903 for HDHP/SOs (Exhibit 7.3).
  - For each of the plan types, there is no statistically significant change in deductible amounts from 2009 to 2010 for single or family coverage. Since 2006, the earliest year for which we have comparable deductible data, the average deductible for workers with PPOs has increased from \$473 to \$675 in 2010 for single coverage (Exhibit 7.5) and, for aggregate family deductibles, from \$1,034 to \$1,518 in 2010 (Exhibit 7.12).
  - Deductibles are generally higher for covered workers in plans sponsored by small firms (3–199 workers) than for covered workers in large firms (200 or more workers) (Exhibit 7.3 and Exhibit 7.11).

- ▶ For family coverage, the majority of workers with general annual deductibles have an aggregate deductible, meaning all family members' out-of-pocket expenses count toward meeting the deductible amount. Among those with a general annual deductible for family coverage, the percentage of covered workers with an aggregate general annual deductible ranges from 65% for PPOs to 89% for HDHP/SOs.
  - The average amounts for workers with an aggregate deductible for family coverage are \$1,321 for HMOs, \$1,518 for PPOs, \$2,253 for POS plans, and \$3,780 for HDHP/SOs (Exhibit 7.11).
- ▶ The other type of family deductible, a separate per-person deductible, requires each family member to meet a separate per-person deductible amount before the plan covers expenses for that member. Most plans with separate per-person family deductibles consider the deductible met if a prescribed number of family members each reach their separate deductible amounts.
  - For covered workers in health plans that have separate per-person general annual deductible amounts for family coverage, the average plan deductible amounts are \$500 for HMOs, \$596 for PPOs, \$1,164 for POS plans, and \$2,053 for HDHP/SOs (Exhibit 7.11). Most covered workers in plans with a separate general annual deductible for family coverage have a limit to the number of family members required to meet the separate deductible amounts (Exhibit 7.14).<sup>1</sup> Among those workers in plans with a limit on the number of family members, the average number of family members required to meet the separate deductible amounts is three for PPOs and HMOs and two for HDHP/SOs.<sup>2</sup>
- ▶ The percentage of workers with deductibles of \$1,000 or more for single coverage continues to increase.
  - From 2006 to 2010, the percentage of covered workers with a deductible of \$1,000 or more for single coverage has almost tripled, from 10% to 27% (Exhibit 7.7). Workers in small firms (3–199 workers) are more likely to have a general annual deductible of \$1,000 or more for single coverage than workers in large firms (200 or more workers) (46% vs. 17%) (Exhibit 7.6).
- ▶ The majority of covered workers with a deductible are in plans where the deductible does not have to be met before certain services, such as physician office visits, preventive care, or prescription drugs, are covered.
  - Roughly four-fifths (83%) of covered workers with general plan deductibles in HMOs, POS plans (81%), and PPOs (70%) are enrolled in plans where the deductible does not have to be met before physician office visits for primary care are covered (Exhibit 7.16).
  - Higher shares of covered workers do not have to meet the deductible before preventive care is covered in HMOs (96%), PPOs (91%), POS plans (87%), and HDHP/SOs (93%) (Exhibit 7.16).
  - Similarly, among workers with a general annual deductible, covered workers in HMOs (94%), PPOs (92%), and POS plans (92%) are enrolled in plans where the general annual deductible does not have to be met before prescription drugs are covered (Exhibit 7.16).

#### HOSPITAL COST SHARING

- ▶ We continue to examine and sometimes modify the questions on hospital and outpatient surgery cost sharing because this can be a complex component of health benefit plans. As in past years, we collected information on the cost-sharing provisions for hospital admissions and outpatient surgery that are in addition to any general annual plan deductible. Beginning with the 2009 survey, in order to better capture the prevalence of combinations of cost sharing, the survey was changed to ask a series of yes or no questions. Previously, the question asked respondents to select one response from a list of types of cost sharing, such as separate deductibles, copayments, coinsurance, and per diem payments

#### NOTE:

<sup>1</sup> Some workers with separate per-person deductibles or out-of-pocket maximums for family coverage do not have a specific number of family members that are required to meet the deductible amount and instead have another type of limit, such as a per-person amount with a total dollar amount limit. These responses are included in the averages and distributions for separate family deductibles and out-of-pocket maximums.

<sup>2</sup> There is insufficient data to report the average number of family members required to meet the separate deductible amount for POS plans.

(for hospitalization only). Due to the change in question format, the distribution of workers with types of cost sharing does not equal 100% as workers may face a combination of types of cost sharing. In addition, the average copayment and coinsurance rate for hospital admissions include workers that may have a combination of types of cost sharing.

- ▶ Whether or not a worker has a general annual deductible, most workers face additional types of cost sharing when admitted to a hospital, such as a copayment, coinsurance, or a per diem charge.
  - The majority of workers have copayments or coinsurance when they are admitted to a hospital, whether or not the worker has a general annual deductible (Exhibit 7.17). Fifty-three percent of covered workers have coinsurance and 19% have copayments for hospital admissions. Lower percentages of workers have per day (per diem) payments (5%), a separate hospital deductible (5%), or both copayments and coinsurance (10%), while 19% have no cost sharing for hospital admissions. For hospital admissions, the average coinsurance rate is 18%, the average copayment is \$232 per hospital admission, the average per diem charge is \$228, and the average separate hospital deductible is \$723 (Exhibit 7.19).
  - The cost-sharing provisions for outpatient surgery are similar to those for hospital admissions, as most workers have coinsurance or copayments. Fifty-eight percent of covered workers have coinsurance and 20% have copayments for an outpatient surgery episode. In addition, 2% have a separate annual deductible for outpatient surgery, and 4% have both copayments and coinsurance, while 20% have no cost sharing for an outpatient surgery (Exhibit 7.18). For covered workers with cost sharing for each outpatient surgery episode, the average coinsurance is 17%, the average copayment is \$132, and the average separate annual outpatient surgery deductible is \$963 (Exhibit 7.19).

#### NOTE:

<sup>3</sup> In 2010, the survey asked about the prevalence and cost of physician office visits separately for primary care and specialty care. Prior to the 2010 survey if the respondent indicated the plan had a copayment for office visits, we assumed the plan had a copayment for both primary and specialty care visits. The survey did not allow for a respondent to report that a plan had a copayment for primary care visits and coinsurance for visits with a specialist physician. The changes made in 2010 allow for variations in the type of cost sharing for primary care and specialty care. This year the survey includes cost sharing for in-network services only. See the 2007 survey for information on out-of-network office visit cost sharing.

<sup>4</sup> The average copayments and the average coinsurance for primary and specialty care include workers who may have a more than one type of cost sharing.

#### COST SHARING FOR PHYSICIAN OFFICE VISITS

- ▶ The majority of covered workers are enrolled in health plans that require cost sharing for an in-network physician office visit, in addition to any general annual deductible.<sup>3</sup>
  - The most common form of physician office visit cost sharing for in-network services is copayments. Seventy-five percent of covered workers have a copayment for a primary care physician office visit and 16% have coinsurance. For office visits with a specialty physician, 73% of covered workers have copayments and 17% have coinsurance. Workers in HMOs, PPOs, and POS plans are much more likely to have copayments than workers in HDHP/SOs for both primary care and specialty care physician office visits. For example, the majority of workers in HDHP/SOs have coinsurance (51%) or no cost sharing (30%) for primary care physician office visits after the deductible is met (Exhibit 7.20).
  - Among covered workers with a copayment for in-network physician office visits, the average copayment is \$22 for primary care and \$31 for specialty physicians (Exhibit 7.22), up significantly from \$20 and \$28 reported in 2009. Forty-nine percent of covered workers have a copayment of \$15 or \$20 for a primary care office visit (Exhibit 7.23). For specialty care office visits, 28% of covered workers have copayments of \$20 or \$25 (Exhibit 7.24).<sup>4</sup>
  - Among workers with coinsurance for in-network physician office visits, the average coinsurance rate for a visit with a primary care or specialty care physician is 18% (Exhibit 7.22).

#### EMERGENCY ROOM VISIT COST SHARING

- ▶ The majority of covered workers have cost sharing when they visit an emergency room.
  - Ninety-two percent of covered workers have cost sharing for emergency room visits (Exhibit 7.21). Sixty-one percent of workers pay a copayment

while 17% pay a coinsurance (Exhibit 7.20). The average copayment is \$107 while the average coinsurance is 17% (Exhibit 7.22).<sup>5</sup>

- Covered workers may find their emergency room cost sharing is waived if they are admitted to the hospital. Among workers with cost sharing for emergency room visits, 72% have the cost sharing waived if they are admitted to the hospital (Exhibit 7.21).

#### OUT-OF-POCKET MAXIMUM AMOUNTS

- ▶ Most covered workers are in a plan that partially or totally limits the cost sharing that a plan enrollee must pay in a year. These limits are generally referred to as out-of-pocket maximum amounts. Enrollee cost sharing such as deductibles, office visit cost sharing, or spending on prescription drugs may or may not apply to the out-of-pocket maximum. Therefore, the survey asks what types of out-of-pocket expenses plans count when determining whether a covered worker has met the plan out-of-pocket maximum. When a plan does not count certain types of spending, it effectively increases the amount a worker may pay out-of-pocket.
- ▶ Eighteen percent of covered workers enrolled in single coverage and 17% of covered workers enrolled in family coverage are in a plan that does not limit the amount of cost sharing enrollees have to pay (Exhibit 7.27).
  - Covered workers with single coverage in HMOs (37%) and POS plans (32%) are more likely to be enrolled in a plan that does not limit the amount of cost sharing than workers in PPOs (13%) (Exhibit 7.27). The percentage of workers without an out-of-pocket maximum in POS plans increased from 19% of covered workers in 2009 to 32% of covered workers in 2010.
  - Covered workers without an out-of-pocket maximum, however, may not have large cost-sharing responsibilities. For example, 78% of covered workers in HMOs with no out-of-pocket maximum for single coverage have no general annual deductible, and only 5% have coinsurance for a hospital admission and 4% have coinsurance for each outpatient surgery episode.
- HSA-qualified HDHPs are required by law to have an out-of-pocket maximum of no more than \$5,950 for single coverage and \$11,900 for family coverage in 2010. HDHP/HRAs have no such requirement, and among workers enrolled in these plans, 8% have no out-of-pocket maximum for single or family coverage.
- ▶ For covered workers with out-of-pocket maximums, there is wide variation in spending limits.
  - Thirty-five percent of workers with an out-of-pocket maximum for single coverage have an out-of-pocket maximum of less than \$2,000, while 31% have an out-of-pocket maximum of \$3,000 or more (Exhibit 7.29).
  - Like deductibles, some plans have an aggregate out-of-pocket maximum amount for family coverage that applies to cost sharing for all family members, while others have a per-person out-of-pocket maximum that limits the amount of cost sharing that the family must pay on behalf of each family member. For covered workers with an aggregate out-of-pocket maximum for family coverage, 33% have an out-of-pocket maximum of less than \$4,000 (Exhibit 7.31). Among workers with separate per-person out-of-pocket limits for family coverage, 83% have out-of-pocket maximums of less than \$4,000 (Exhibit 7.32).
- ▶ As noted above, covered workers with an out-of-pocket maximum may be enrolled in a plan where not all spending counts toward the out-of-pocket maximum, potentially exposing workers to higher out-of-pocket spending.
  - Among workers enrolled in PPO plans with an out-of-pocket maximum for single or family coverage, 32% are in plans that do not count spending for the general annual deductible toward the out-of-pocket limit (Exhibit 7.28).
  - It is more common for covered workers to be in plans that do not count prescription drug cost sharing toward the out-of-pocket limit. Eighty percent of workers in PPOs and 75% in HMOs are in plans that do not count prescription drug spending towards the out-of-pocket maximum (Exhibit 7.28).

#### NOTE:

<sup>5</sup> The average copayments and the average coinsurance for emergency room visits include workers who may have more than one type of cost sharing.

EXHIBIT 7.1

Percentage of Covered Workers with No General Annual Health Plan Deductible for Single and Family Coverage, by Plan Type and Firm Size, 2010

	Single Coverage	Family Coverage
<b>HMO</b>		
200–999 Workers	68%	68%
1,000–4,999 Workers	80	80
5,000 or More Workers	77	77
<b>All Small Firms (3–199 Workers)</b>	<b>66%</b>	<b>65%</b>
<b>All Large Firms (200 or More Workers)</b>	<b>75%</b>	<b>75%</b>
<b>ALL FIRM SIZES</b>	<b>72%</b>	<b>72%</b>
<b>PPO</b>		
200–999 Workers	26%	26%
1,000–4,999 Workers	24	24
5,000 or More Workers	23	23
<b>All Small Firms (3–199 Workers)</b>	<b>20%</b>	<b>20%</b>
<b>All Large Firms (200 or More Workers)</b>	<b>24%</b>	<b>24%</b>
<b>ALL FIRM SIZES</b>	<b>23%</b>	<b>23%</b>
<b>POS</b>		
200–999 Workers	34%	34%
1,000–4,999 Workers	70*	70*
5,000 or More Workers	15*	15*
<b>All Small Firms (3–199 Workers)</b>	<b>36%</b>	<b>32%</b>
<b>All Large Firms (200 or More Workers)</b>	<b>30%</b>	<b>30%</b>
<b>ALL FIRM SIZES</b>	<b>34%</b>	<b>31%</b>

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different within plan type from estimate for all other firms not in the indicated size category ( $p < .05$ ).

Note: HDHP/SOs are not shown because all covered workers in these plans face a minimum deductible. In HDHP/HRA plans, as defined by the survey, the minimum deductible is \$1,000 for single coverage and \$2,000 for family coverage. In HSA-qualified HDHPs, the legal minimum deductible for 2010 is \$1,200 for single coverage and \$2,400 for family coverage. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

## EXHIBIT 7.2

Among Covered Workers with No General Annual Health Plan Deductible for Single and Family Coverage, Percentage Who Have the Following Types of Cost Sharing, by Plan Type, 2010<sup>‡</sup>

	Single Coverage	Family Coverage
<b>Separate Cost Sharing for a Hospital Admission</b>		
HMO	78%	78%
PPO	75	75
POS	74	71
<b>Separate Cost Sharing for an Outpatient Surgery Episode</b>		
HMO	74%	74%
PPO	72	72
POS	72	70

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

<sup>‡</sup> Separate cost sharing for each hospital admission includes the following types: separate annual deductible, copayment, coinsurance, and/or a charge per day (per diem). Cost sharing for each outpatient surgery episode includes the following types: separate annual deductible, copayment, and/or coinsurance.

Note: HDHP/SOs are not shown because all covered workers in these plans face a deductible. In HDHP/HRA plans, as defined by the survey, the minimum deductible is \$1,000 for single coverage and \$2,000 for family coverage. In HSA-qualified HDHPs, the legal minimum deductible for 2010 is \$1,200 for single coverage and \$2,400 for family coverage. Average general annual health plan deductibles for PPOs and POS plans are for in-network services.

EXHIBIT 7.3

Among Covered Workers with a General Annual Health Plan Deductible for Single Coverage, Average Deductible, by Plan Type and Firm Size, 2010

	Single Coverage
<b>HMO</b>	
All Small Firms (3–199 Workers)	\$998*
All Large Firms (200 or More Workers)	354*
<b>ALL FIRM SIZES</b>	<b>\$601</b>
<b>PPO</b>	
All Small Firms (3–199 Workers)	\$1,146*
All Large Firms (200 or More Workers)	460*
<b>ALL FIRM SIZES</b>	<b>\$675</b>
<b>POS</b>	
All Small Firms (3–199 Workers)	\$1,278*
All Large Firms (200 or More Workers)	687*
<b>ALL FIRM SIZES</b>	<b>\$1,048</b>
<b>HDHP/SO</b>	
All Small Firms (3–199 Workers)	\$2,216*
All Large Firms (200 or More Workers)	1,676*
<b>ALL FIRM SIZES</b>	<b>\$1,903</b>

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimates are statistically different within plan type between All Small Firms and All Large Firms ( $p < .05$ ).

Note: Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

## EXHIBIT 7.4

Among Covered Workers with a General Annual Health Plan Deductible for Single Coverage,  
Average Deductible, by Plan Type and Region, 2010\*

	Single Coverage
<b>HMO</b>	
Northeast	\$693
Midwest	516
South	696
West	NSD
<b>ALL REGIONS</b>	<b>\$601</b>
<b>PPO</b>	
Northeast	\$561
Midwest	660
South	673
West	814
<b>ALL REGIONS</b>	<b>\$675</b>
<b>POS</b>	
Northeast	NSD
Midwest	\$908
South	1,065
West	NSD
<b>ALL REGIONS</b>	<b>\$1,048</b>
<b>HDHP/SO</b>	
Northeast	\$1,765
Midwest	2,000
South	1,902
West	1,868
<b>ALL REGIONS</b>	<b>\$1,903</b>

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Tests found no statistical differences by region ( $p < .05$ ).

NSD: Not Sufficient Data.

Note: Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

EXHIBIT 7.5

Among Covered Workers with a General Annual Health Plan Deductible for Single Coverage, Average Deductible, by Plan Type, 2006–2010

	2006	2007	2008	2009	2010
HMO	\$352	\$401	\$503	\$699*	\$601
PPO	473	461	560*	634	675
POS	553	621	752	1,061	1,048
HDHP/SO	1,715	1,729	1,812	1,838	1,903

SOURCE:

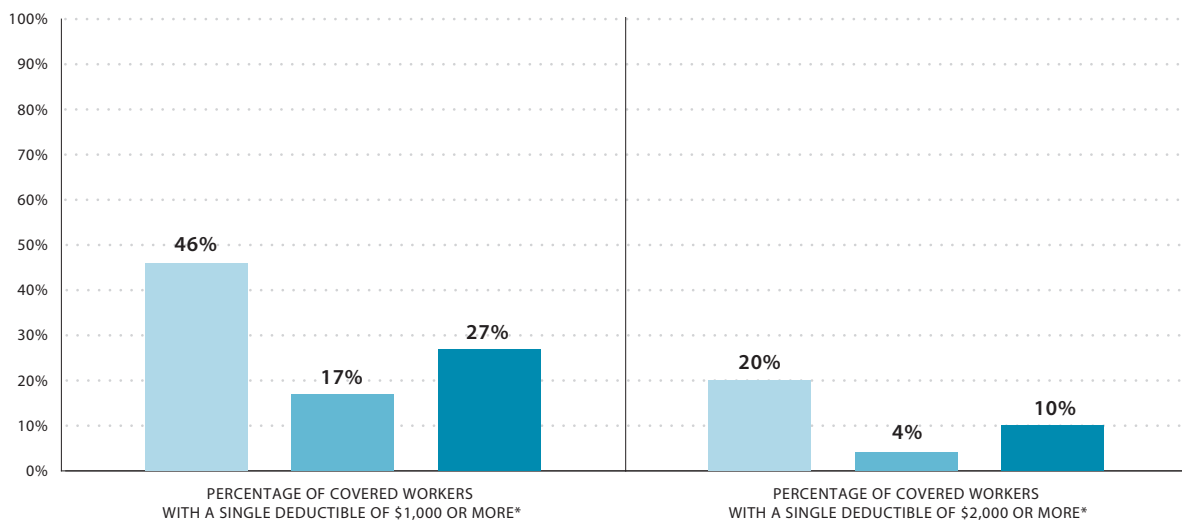
Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006–2010.

\* Estimate is statistically different from estimate for the previous year shown by plan type ( $p < .05$ ).

Note: Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

EXHIBIT 7.6

Percentage of Covered Workers Enrolled in a Plan with a High General Annual Deductible for Single Coverage, By Firm Size, 2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

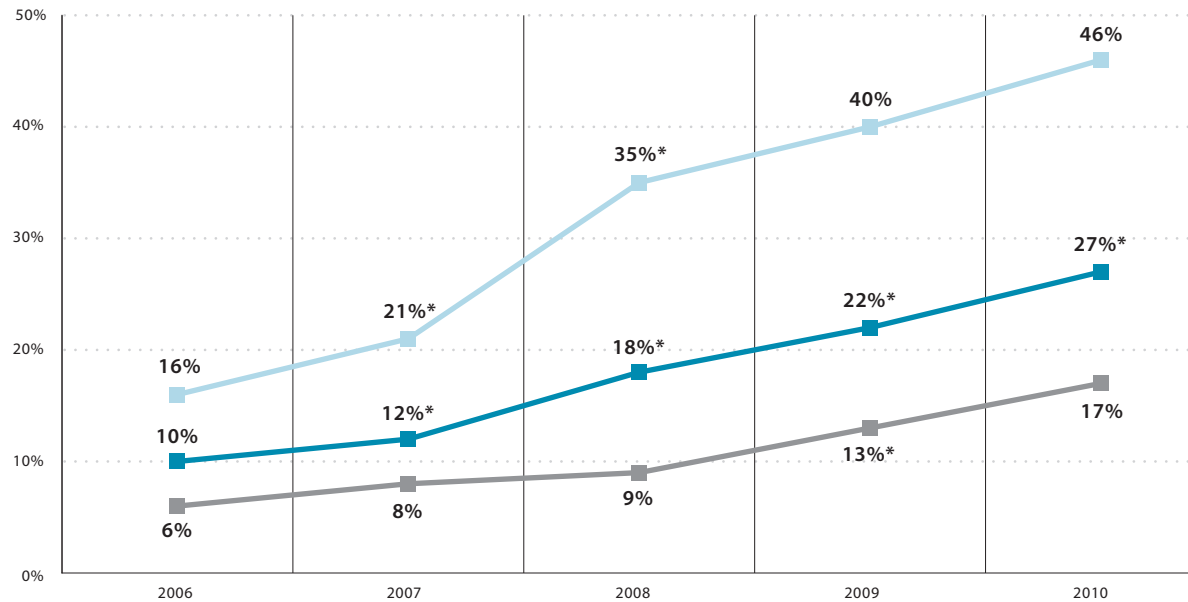
\* Estimate is statistically different between All Small Firms and All Large Firms within category ( $p < .05$ ).

Note: These estimates include workers enrolled in HDHP/SO and other plan types. Because we do not collect information on the attributes of conventional plans, to be conservative, we assumed that workers in conventional plans do not have a deductible of \$1,000 or more. Because of the low enrollment in conventional plans, the impact of this assumption is minimal. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

ALL SMALL FIRMS  
(3–199 WORKERS)  
ALL LARGE FIRMS  
(200 OR MORE WORKERS)  
ALL FIRMS

EXHIBIT 7.7

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of \$1,000 or More for Single Coverage, By Firm Size, 2006–2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006–2010.

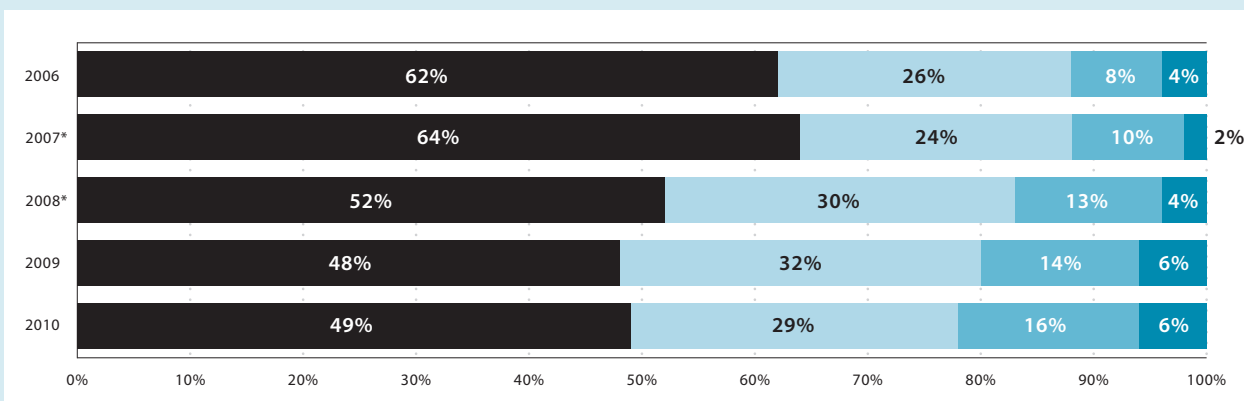
\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

Note: These estimates include workers enrolled in HDHP/SO and other plan types. Because we do not collect information on the attributes of conventional plans, to be conservative, we assumed that workers in conventional plans do not have a deductible of \$1,000 or more. Because of the low enrollment in conventional plans, the impact of this assumption is minimal. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

— ALL SMALL FIRMS  
(3–199 WORKERS)  
— ALL LARGE FIRMS  
(200 OR MORE WORKERS)  
— ALL FIRMS

EXHIBIT 7.8

Among Covered Workers with a General Annual Health Plan Deductible for Single PPO Coverage, Distribution of Deductibles, 2006–2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006–2010.

\* Distribution is statistically different from distribution for the previous year shown ( $p < .05$ ).

Note: Deductibles for PPO plans are for in-network services.

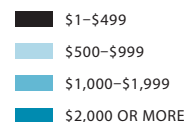
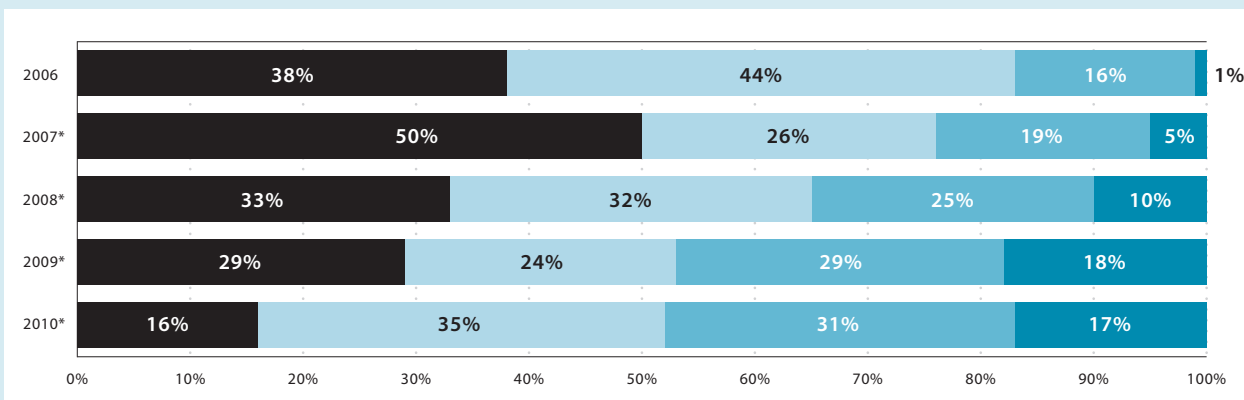


EXHIBIT 7.9

Among Covered workers with a General Annual Health Plan Deductible for Single POS Coverage, Distribution of Deductibles, 2006–2010

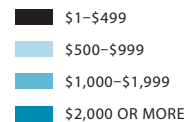


SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006–2010.

\* Distribution is statistically different from distribution for the previous year shown ( $p < .05$ ).

Note: Deductibles for POS plans are for in-network services.



## EXHIBIT 7.10

Distribution of Type of General Annual Deductible for Covered Workers with Family Coverage, by Plan Type and Firm Size, 2010\*

	No Deductible	Aggregate Amount	Separate Amount per Person
<b>HMO</b>			
All Small Firms (3–199 Workers)	65%	28%	7%
All Large Firms (200 or More Workers)	75	18	7
<b>ALL FIRM SIZES</b>	<b>72%</b>	<b>21%</b>	<b>7%</b>
<b>PPO</b>			
All Small Firms (3–199 Workers)	20%	56%	24%
All Large Firms (200 or More Workers)	24	47	29
<b>ALL FIRM SIZES</b>	<b>23%</b>	<b>50%</b>	<b>27%</b>
<b>POS</b>			
All Small Firms (3–199 Workers)	32%	50%	18%
All Large Firms (200 or More Workers)	30	62	8
<b>ALL FIRM SIZES</b>	<b>31%</b>	<b>54%</b>	<b>14%</b>
<b>HDHP/SO</b>			
All Small Firms (3–199 Workers)	NA	85%	15%
All Large Firms (200 or More Workers)	NA	91	9
<b>ALL FIRM SIZES</b>	<b>NA</b>	<b>89%</b>	<b>11%</b>

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Tests found no statistical difference between distributions for All Small Firms and All Large Firms within plan type ( $p < .05$ ).

NA: Not Applicable. All covered workers in HDHP/SOs face a general annual deductible. In HDHP/HRA plans, as defined by the survey, the minimum deductible is \$1,000 for single coverage and \$2,000 for family coverage. In HSA-qualified HDHPs, the legal minimum deductible for 2010 is \$1,200 for single coverage and \$2,400 for family coverage.

Note: The survey distinguished between plans that have an aggregate deductible amount in which all family members' out-of-pocket expenses count toward the deductible and plans that have a separate amount for each family member, typically with a limit on the number of family members required to reach that amount. Among workers with a general annual deductible, 76% of workers in HMOs have an aggregate deductible, 65% in PPOs have an aggregate deductible, and 79% in POS plans have an aggregate deductible. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

EXHIBIT 7.11

Among Covered Workers with a General Annual Health Plan Deductible, Average Deductibles for Family Coverage, by Deductible Type, Plan Type, and Firm Size, 2010

	Aggregate Amount	Separate Amount per Person
<b>HMO</b>		
All Small Firms (3–199 Workers)	\$2,138*	NSD
All Large Firms (200 or More Workers)	774*	\$344
<b>ALL FIRM SIZES</b>	<b>\$1,321</b>	<b>\$500</b>
<b>PPO</b>		
All Small Firms (3–199 Workers)	\$2,347*	\$1,065*
All Large Firms (200 or More Workers)	1,103*	430*
<b>ALL FIRM SIZES</b>	<b>\$1,518</b>	<b>\$596</b>
<b>POS</b>		
All Small Firms (3–199 Workers)	\$2,596	NSD
All Large Firms (200 or More Workers)	1,806	NSD
<b>ALL FIRM SIZES</b>	<b>\$2,253</b>	<b>\$1,164</b>
<b>HDHP/SO</b>		
All Small Firms (3–199 Workers)	\$4,306*	NSD
All Large Firms (200 or More Workers)	3,429*	\$1,815
<b>ALL FIRM SIZES</b>	<b>\$3,780</b>	<b>\$2,053</b>

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimates are statistically different within plan and deductible type between All Small Firms and All Large Firms ( $p < .05$ ).

NSD: Not Sufficient Data.

Note: Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services. The survey distinguished between plans that have an aggregate deductible amount in which all family members' out-of-pocket expenses count toward the deductible and plans that have a separate amount for each family member, typically with a limit on the number of family members required to reach that amount.

## EXHIBIT 7.12

Among Covered Workers with a General Annual Health Plan Deductible for Family Coverage,  
Average Aggregate Deductible, by Plan Type, 2006–2010

	2006	2007	2008	2009	2010
HMO	\$751	\$759	\$1,053	\$1,524*	\$1,321
PPO	\$1,034	\$1,040	\$1,344*	\$1,488	\$1,518
POS	\$1,227	\$1,359	\$1,860	\$2,191	\$2,253
HDHP/SO	\$3,511	\$3,596	\$3,559	\$3,626	\$3,780

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006–2010.

\* Estimate is statistically different from estimate for the previous year shown by plan type ( $p < .05$ ).

Note: Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

## EXHIBIT 7.13

Among Covered Workers with a General Annual Health Plan Deductible for Family Coverage,  
Distribution of Deductibles, by Plan Type and Deductible Type, 2010

	\$1–\$499	\$500–\$999	\$1,000–\$1,999	\$2,000 or More
<b>HMO</b>				
Aggregate Amount	28%	9%	36%	27%
Separate Amount	50%	33%	16%	1%
<b>PPO</b>				
Aggregate Amount	7%	33%	35%	24%
Separate Amount	58%	24%	12%	6%
<b>POS</b>				
Aggregate Amount	7%	9%	21%	63%
Separate Amount	18%	22%	37%	23%
<b>HDHP/SO<sup>†</sup></b>				
Aggregate Amount	0%	0%	0%	100%
Separate Amount	0%	0%	48%	52%

## SOURCE:

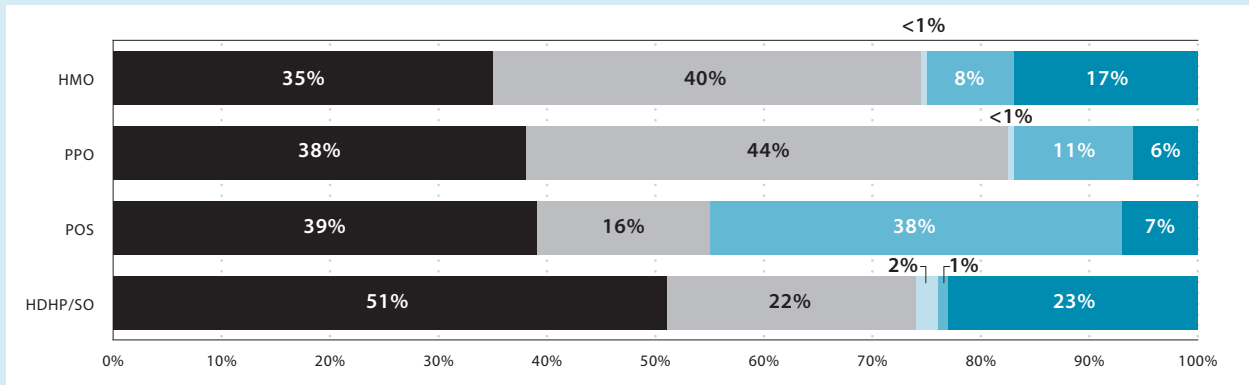
Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

<sup>†</sup> By definition, 100% of covered workers in HDHP/SOs with an aggregate deductible have a family deductible of \$2,000 or more.

Note: Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services. The survey distinguished between plans that have an aggregate deductible amount in which all family members' out-of-pocket expenses count toward the deductible and plans that have a separate amount for each family member, typically with a limit on the number of family members required to reach that amount.

EXHIBIT 7.14

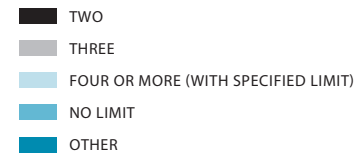
Among Covered Workers with a Separate per Person General Annual Health Plan Deductible for Family Coverage, Distribution of Maximum Number of Family Members Required to Meet the Deductible, by Plan Type, 2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

Note: Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services. The survey distinguished between plans that have an aggregate deductible amount in which all family members' out-of-pocket expenses count toward the deductible and plans that have a separate amount for each family member, typically with a limit on the number of family members required to reach that amount. The "other" category refers to workers that have another type of limit on per-person deductibles, such as a per-person amount with a total dollar cap.



## EXHIBIT 7.15

Among Covered Workers with an Aggregate General Annual Health Plan Deductible for Family Coverage, Distribution of Aggregate Deductibles, by Plan Type, 2006–2010

	\$1–\$499	\$500–\$999	\$1,000–\$1,999	\$2,000 or More
<b>HMO</b>				
2006	27%	42%	23%	7%
2007	22	48	23	8
2008*	31	26	20	23
2009*	7	22	33	38
2010*	28	9	36	27
<b>PPO</b>				
2006	20%	42%	27%	12%
2007*	14	49	25	12
2008*	11	38	32	19
2009*	12	30	35	23
2010	7	33	35	24
<b>POS</b>				
2006	12%	26%	45%	18%
2007*	32	13	29	25
2008	23	14	24	39
2009*	3	18	30	49
2010	7	9	21	63

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006–2010.

\* Distribution is statistically different from distribution for the previous year shown ( $p < .05$ ).

Note: By definition, 100% of covered workers in HDHP/SOs with an aggregate deductible have a family deductible of \$2,000 or more. Average general annual health plan deductibles for PPOs and POS plans are for in-network services. The survey distinguished between plans that have an aggregate deductible amount in which all family members' out-of-pocket expenses count toward the deductible and plans that have a separate amount for each family member, typically with a limit on the number of family members required to reach that amount.

## EXHIBIT 7.16

Among Covered Workers with a General Annual Health Plan Deductible, Percentage with Coverage for the Following Services Without Having to First Meet the Deductible, by Plan Type, 2010

	HMO	PPO	POS	HDHP/SO
Physician Office Visits For Primary Care	83%	70%	81%	37% <sup>§</sup>
Preventive Care	96%	91%	87%	93%
Prescription Drugs	94%	92%	92%	56% <sup>§</sup>

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

<sup>§</sup> Percentage is for covered workers in HDHP/HRAs only. Both HDHP/HRAs and HSA-qualified HDHPs were asked about preventive benefits, but only HDHP/HRAs were asked about physician office visits for primary care and prescription drugs. HSA-qualified HDHPs are required by law to apply the plan deductible to nearly all services.

Note: These questions are asked of firms with a deductible for single or family coverage. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

## EXHIBIT 7.17

Distribution of Covered Workers with Separate Cost Sharing for a Hospital Admission in Addition to Any General Annual Deductible, by Plan Type, 2010

Separate Cost Sharing for a Hospital Admission	HMO	PPO	POS	HDHP/SO <sup>§</sup>	ALL PLANS
Separate Annual Deductible for Hospitalizations	5%	6%	2%*	<1%*	5%
Copayment and/or Coinsurance					
Copayment	44*	16	25	2*	19
Coinsurance	17*	63*	37*	59	53
Both Copayment and Coinsurance <sup>†</sup>	10	10	16	<1*	10
Charge Per Day	11*	3*	14	1*	5
None	22	15*	20	38*	19

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different from All Plans estimate ( $p < .05$ ).

<sup>†</sup> This includes enrollees who are required to pay the higher amount of either the copayment or coinsurance under the plan.

<sup>§</sup> Information on separate deductibles for hospital admissions was collected only for HDHP/HRAs because federal regulations for HSA-qualified HDHPs make it unlikely these plans would have a separate deductible for specific services.

Note: As in past years, we collected information on the cost-sharing provisions for hospital admissions that are in addition to any general annual plan deductible. However, beginning with the 2009 survey, in order to better capture the prevalence of combinations of cost sharing, the survey was changed to ask a series of yes or no questions. Previously, the question asked respondents to select one response from a list of types of cost sharing, such as separate deductibles, copayments, coinsurance, and per diem payments (for hospitalization only). Due to the change in question format, the distribution of workers with types of cost sharing does not equal 100% as workers may face a combination of types of cost sharing. Less than 1% of covered workers have an "other" type of cost sharing for a hospital admission.

## EXHIBIT 7.18

## Distribution of Covered Workers with Separate Cost Sharing for an Outpatient Surgery in Addition to Any General Annual Deductible, by Plan Type, 2010

Separate Cost Sharing for an Outpatient Surgery	HMO	PPO	POS	HDHP/SO <sup>§</sup>	ALL PLANS
Separate Annual Deductible for Outpatient Surgery	4%	1%	<1%*	1%	2%
Copayment and/or Coinsurance					
Copayment	48*	13*	28	4*	20
Coinsurance	22*	70*	49	59	58
Both Copayment and Coinsurance <sup>‡</sup>	3	5	4	0*	4
None	27	16	21	37*	20

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different from All Plans estimate ( $p < .05$ ).<sup>‡</sup> This includes enrollees who are required to pay the higher amount of either the copayment or coinsurance under the plan.<sup>§</sup> Information on separate deductibles for outpatient surgery was collected only for HDHP/HRAs because federal regulations for HSA-qualified HDHPs make it unlikely these plans would have a separate deductible for specific services.

Note: As in past years, we collected information on the cost-sharing provisions for outpatient surgery that are in addition to any general annual plan deductible. However, beginning with the 2009 survey, in order to better capture the prevalence of combinations of cost sharing, the survey was changed to ask a series of yes or no questions. Previously, the question asked respondents to select one response from a list of types of cost sharing, such as separate deductibles, copayments, coinsurance, and per diem payments (for hospitalization only). Due to the change in question format, the distribution of workers with types of cost sharing does not equal 100% as workers may face a combination of types of cost sharing. Less than 1% of covered workers have an "other" type of cost sharing for an outpatient surgery.

EXHIBIT 7.19

Among Covered Workers with Separate Cost Sharing for a Hospital Admission or Outpatient Surgery in Addition to Any General Annual Deductible, Average Cost Sharing, by Plan Type, 2010

	Average Copayment	Average Coinsurance	Charge Per Day
<b>Separate Cost Sharing for a Hospital Admission</b>			
HMO	\$267	17%	\$245
PPO	213	17	157*
POS	206	19	303
HDHP/SO	NSD	19	NSD
<b>ALL PLANS</b>	<b>\$232</b>	<b>18%</b>	<b>\$228</b>
<b>Separate Cost Sharing for an Outpatient Surgery</b>			
HMO	\$134	16%	NA
PPO	127	17	NA
POS	146	18	NA
HDHP/SO	NSD	19	NA
<b>ALL PLANS</b>	<b>\$132</b>	<b>17%</b>	<b>NA</b>

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different from All Plans estimate ( $p < .05$ ).

NSD: Not Sufficient Data.

NA: Not applicable. The survey did not offer "Charge Per Day" (per diem) as a response option for questions about separate cost sharing for each outpatient surgery episode.

Note: The average separate annual deductible for hospital admission is \$723 and the average separate deductible for outpatient surgery is \$963. In most cases there were too few observations to present the average estimates by plan type. The average amounts include workers who may have a combination of types of cost sharing. All Plans estimates are weighted by workers in firms that reported cost sharing. See the Survey Design and Methods Section for more information on weighting.

## EXHIBIT 7.20

In Addition to Any General Annual Plan Deductible, Percentage of Covered Workers with the Following Types of Cost Sharing for Physician Office Visits and Emergency Room Visits, by Plan Type, 2010

	Copay Only	Coinsurance Only	Both Copay and Coinsurance <sup>†</sup>	No Cost Sharing	None of the Above
<b>Primary Care</b>					
HMO*	94%	1%	4%	1%	<1%
PPO*	80	16	3	1	<1
POS*	90	4	3	2	0
HDHP/SO*	15	51	3	30	2
<b>ALL PLANS</b>	<b>75%</b>	<b>16%</b>	<b>3%</b>	<b>5%</b>	<b>&lt;1%</b>
<b>Specialty Care</b>					
HMO*	93%	1%	4%	2%	<1%
PPO*	77	17	3	3	1
POS*	90	5	4	2	<1
HDHP/SO*	13	50	3	32	2
<b>ALL PLANS</b>	<b>73%</b>	<b>17%</b>	<b>3%</b>	<b>6%</b>	<b>1%</b>
<b>Emergency Room Visits</b>					
HMO*	85%	5%	6%	4%	0%
PPO*	62	18	13	5	1
POS*	69	10	19	2	<1
HDHP/SO*	15	37	15	31	1
<b>ALL PLANS</b>	<b>61%</b>	<b>17%</b>	<b>13%</b>	<b>8%</b>	<b>1%</b>

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Distribution is statistically different from All Plans distribution ( $p < .05$ ).

<sup>†</sup> This includes enrollees who are required to pay the higher amount of either the copayment or coinsurance under the plan.

Note: In 2010, the survey includes questions on cost sharing for in-network services only. See the 2007 survey for information on out-of-network office visit cost sharing. In 2010, the survey asked about the prevalence and cost of physician office visits separately for primary care and specialty care. Prior to the 2010 survey if the respondent indicated the plan had a copayment for office visits, we assumed the plan had a copayment for both primary and specialty care visits. The survey did not allow for a respondent to report that a plan had a copayment for primary care visits and coinsurance for visits with a specialist physician. The changes made in 2010 allow for variations in the type of cost sharing for primary care and specialty care.

EXHIBIT 7.21

In Addition to Any Plan Deductible, Percentage of Covered Workers with Emergency Room Cost Sharing, by Plan Type, 2010

	Percentage of Covered Workers with Emergency Room Cost Sharing	Among Workers with Emergency Room Cost Sharing, Percentage of Covered Workers with Cost Sharing Waived if Individual is Admitted to the Hospital
HMO	96%*	85%*
PPO	95*	71
POS	98*	82*
HDHP/SO	69*	48*
<b>ALL PLANS</b>	<b>92%</b>	<b>72%</b>

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different from All Plans estimate ( $p < .05$ ).

EXHIBIT 7.22

Among Covered Workers with Copayments and/or Coinsurance for In-Network Physician Office and Emergency Room Visits, Average Copayments and Coinsurance, by Plan Type, 2010

	HMO	PPO	POS	HDHP/SO	ALL PLANS
<b>Primary Care</b>					
Average Copay for Primary Care Physician Office Visit	\$21*	\$22	\$24*	\$25	\$22
Average Coinsurance for Primary Care Physician Office Visit	NSD	18%	NSD	18%	18%
<b>Specialty Care</b>					
Average Copay for Specialist Physician Office Visit	\$29	\$31	\$36	\$34	\$31
Average Coinsurance for Specialist Physician Office Visit	NSD	18%	NSD	18%	18%
<b>Emergency Room Visits</b>					
Average Copay for Emergency Room Visits	\$95*	\$109	\$110	\$124*	\$107
Average Coinsurance for Emergency Room Visits	15%	17%	19%*	17%	17%

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different from All Plans estimate ( $p < .05$ ).

NSD: Not Sufficient Data.

Note: The survey asks respondents if the plan has cost sharing for in-network office visits. In 2010, the survey asked about the prevalence and cost of physician office visits separately for primary care and specialty care. Prior to the 2010 survey if the respondent indicated the plan had a copayment for office visits, we assumed the plan had a copayment for both primary and specialty care visits. The survey did not allow for a respondent to report that a plan had a copayment for primary care visits and coinsurance for visits with a specialist physician. The changes made in 2010 allow for variations in the type of cost sharing for primary care and specialty care.

## EXHIBIT 7.23

Among Covered Workers with Copayments for a Physician Office Visit with a Primary Care Physician, Distribution of Copayments, by Plan Type, 2004–2010

	\$5 Per Visit	\$10 Per Visit	\$15 Per Visit	\$20 Per Visit	\$25 Per Visit	\$30 Per Visit	Other
<b>HMO</b>							
2004	3%	28%	40%	22%	3%	3%	1%
2005*	5	23	34	27	6	4	1
2006	3	21	37	25	8	5	2
2007*	3	20	25	34	13	4	1
2008*	6	16	29	30	11	5	3
2009	5	11	29	31	13	8	3
2010*	1	8	22	38	15	12	4
<b>PPO</b>							
2004	1%	17%	35%	28%	11%	4%	3%
2005*	<1	16	25	34	15	5	4
2006	<1	12	25	35	17	7	3
2007*	2	11	24	35	19	7	2
2008	1	11	22	34	21	8	3
2009*	<1	11	18	34	23	11	2
2010*	1	7	16	31	25	13	6
<b>POS</b>							
2004	3%	17%	34%	36%	8%	<1%	1%
2005*	2	16	35	30	11	6	1
2006*	2	22	26	27	16	6	<1
2007*	2	10	36	25	15	6	5
2008*	2	14	19	27	21	12	7
2009*	1	8	14	39	21	12	4
2010*	1	7	11	24	20	29	8
<b>HDHP/SO<sup>†</sup></b>							
2007	7%	<1%	12%	38%	13%	19%	12%
2008	0	2	17	33	9	18	21
2009	<1	4	24	29	11	29	4
2010	0	2	17	34	10	17	20
<b>ALL PLANS</b>							
2004	1%	19%	37%	27%	9%	3%	3%
2005*	2	17	29	32	12	5	3
2006	2	15	28	32	15	6	3
2007	2	14	25	34	17	7	2
2008	2	13	23	33	18	8	4
2009*	2	10	21	34	20	11	2
2010*	1	7	18	32	22	15	6

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2004–2010.

\* Distribution is statistically different from distribution for the previous year shown ( $p < .05$ ).

† There are insufficient data to report the results from the 2006 survey. Information was not obtained for HDHP/SOs prior to 2006.

Note: Copayments for PPO, POS, and HDHP/SO plans are for in-network providers. The survey has asked specifically about copayments for primary care physicians since 2005. In 2004, the survey question did not specify primary or specialist physician.

## EXHIBIT 7.24

Among Covered Workers with Copayments for a Physician Office Visit with a Specialty Care Physician, Distribution of Copayments, by Plan Type, 2006–2010

	\$5 Per Visit	\$10 Per Visit	\$15 Per Visit	\$20 Per Visit	\$25 Per Visit	\$30 Per Visit	\$35 Per Visit	\$40 Per Visit	Other
<b>HMO</b>									
2006	3%	14%	20%	20%	17%	13%	5%	5%	4%
2007*	2	11	12	26	22	14	5	7	2
2008*	2	13	14	18	20	16	5	5	7
2009*	3	6	17	15	17	18	7	9	8
2010*	1	4	9	18	12	18	9	19	10
<b>PPO</b>									
2006	<1%	9%	15%	25%	20%	15%	6%	5%	5%
2007	1	8	13	24	18	16	8	7	4
2008*	<1	7	14	21	17	15	9	9	8
2009*	<1	8	10	20	14	15	11	11	11
2010*	1	4	8	14	15	16	12	17	14
<b>POS</b>									
2006	2%	13%	13%	17%	18%	17%	8%	5%	8%
2007*	7	6	10	21	19	16	6	6	9
2008*	1	7	8	14	13	21	11	9	17
2009	1	4	5	17	11	25	6	14	17
2010*	1	5	4	10	15	17	6	10	31
<b>HDHP/SO<sup>‡</sup></b>									
2007	0%	7%	5%	23%	7%	18%	5%	21%	15%
2008	0	2	11	18	4	27	3	9	28
2009	<1	4	11	18	8	23	15	11	9
2010	0	2	5	16	12	12	5	22	26
<b>ALL PLANS</b>									
2006	2%	10%	15%	22%	19%	16%	6%	5%	5%
2007	2	8	12	24	20	16	6	7	5
2008*	1	9	13	18	17	16	8	8	10
2009*	1	7	11	18	14	17	10	11	11
2010*	1	4	8	14	14	17	10	18	15

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006–2010.

\* Distribution is statistically different from distribution for the previous year shown ( $p < .05$ ).

‡ There are insufficient data to report the results from the 2006 survey.

Note: Copayments for PPO, POS, and HDHP/SO plans are for in-network providers. Information on copayments for specialty physician office visits was not obtained prior to 2006. The survey asks respondents if the plan has cost sharing for in-network office visits. Prior to the 2010 survey if the respondent indicated the plan had a copayment for office visits, we assumed the plan had a copayment for both primary and specialty care visits. The survey did not allow for a respondent to report that a plan had a copayment for primary care visits and coinsurance for visits with a specialist physician. The changes made in 2010 allow for variations in the type of cost sharing for primary care and specialty care.

## EXHIBIT 7.25

Among Covered Workers in HMOs with Copayments for a Physician Office Visit, Distribution of Percentage of Workers with Various Copayments, 1999–2010

	\$5 Per Visit	\$10 Per Visit	\$15 Per Visit	\$20 Per Visit	Other
1999	23%	60%	12%	1%	3%
2000*	22	54	16	3	6
2001*	15	56	22	3	4
2002*	7	52	27	11	3
2003*	4	35	37	12	12
2004*	3	28	40	22	7
2005*	5	23	34	27	11
2006	3	21	37	25	15
2007*	3	20	25	34	18
2008*	6	16	29	30	19
2009	5	11	29	31	24
2010*	1	8	22	38	31

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

\* Distribution is statistically different from distribution for the previous year shown ( $p < .05$ ).

Note: The survey has asked specifically about copayments for primary care physicians since 2005. Prior to 2005, the survey question did not specify primary or specialist physician.

## EXHIBIT 7.26

Among Covered Workers with Coinsurance for Physician Office Visits, Distribution of Average Coinsurance Rates, by Plan Type, 2010

Coinsurance Rates	10% or 15%	20% or 25%	30% or 35%	40% or 45%	Other
<b>Primary Care</b>					
PPO	31%	67%	2%	<1%	1%
HDHP/SO	40	53	7	0	1
<b>ALL PLANS</b>	<b>33%</b>	<b>64%</b>	<b>3%</b>	<b>&lt;1%</b>	<b>&lt;1%</b>
<b>Specialty Care</b>					
PPO	27%	70%	2%	1%	1%
HDHP/SO*	39	50	6	0	4
<b>ALL PLANS</b>	<b>30%</b>	<b>65%</b>	<b>3%</b>	<b>&lt;1%</b>	<b>2%</b>

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Distribution is statistically different from All Plans distribution ( $p < .05$ ).

Note: Coinsurance rates for HMO and POS plans are not shown because there is not sufficient data as only 1% or 4% of covered workers, respectively, face coinsurance for primary care office visits and 1% or 5% of covered workers, respectively, face coinsurance for specialty care office visits.

## EXHIBIT 7.27

## Percentage of Covered Workers Without an Annual Out-of-Pocket Maximum for Single and Family Coverage, by Plan Type, 2010

	Single Coverage	Family Coverage
HMO	37%*	38%*
PPO	13*	13*
POS	32*	30*
HDHP/SO	NA	NA
<b>ALL PLANS</b>	<b>18%</b>	<b>17%</b>

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Estimate is statistically different from All Plans estimate ( $p < .05$ ).

NA: Not Applicable. HSA-qualified HDHPs are required to have an annual maximum out-of-pocket liability of no more than \$5,950 for single coverage and \$11,900 for family coverage in 2010. HDHP/HRAs have no such requirement, and the percentage of covered workers in HDHP/HRAs with "No Limit" for annual out-of-pocket maximum for single and family coverage is 8% and 8%, respectively.

## EXHIBIT 7.28

## Among Covered Workers with an Annual Out-of-Pocket Maximum, Percentage Whose Spending for Various Services Does Not Count Towards the Out-of-Pocket Maximum, 2010

	HMO	PPO	POS	HDHP/SO <sup>‡</sup>
General Annual Plan Deductible	19%	32%	20%	9%
Any Additional Plan Deductibles	NSD	57%	NSD	NSD
Physician Office Visit Copayments	54%	74%	50%	53%
Physician Office Visit Coinsurance	NSD	4%	NSD	1%
Prescription Drug Cost Sharing	75%	80%	73%	42%

## SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

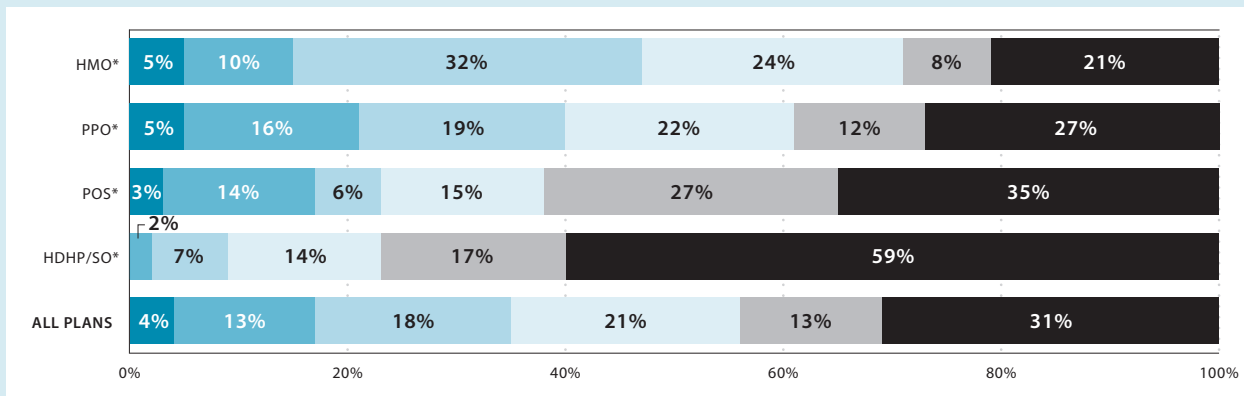
<sup>‡</sup> Among HDHP/SO plans, questions other than "overall plan deductible" were asked only of HDHP/HRAs and not of HSA-qualified HDHPs. HSA-qualified HDHPs are required to apply most cost sharing to the out-of-pocket maximum. When HDHP/HRAs are considered exclusively, among covered workers with an annual out-of-pocket maximum, the percentage whose out-of-pocket maximum does not include certain services is as follows: any additional plan deductibles is NSD, office visit copayments is 52%, office visit coinsurance is 1%, and prescription drug cost sharing is 42%.

NSD: Not Sufficient Data.

Note: This series of questions is asked if the plan has an out-of-pocket maximum for single or family coverage.

EXHIBIT 7.29

Among Covered Workers with an Out-of-Pocket Maximum for Single Coverage, Distribution of Out-of-Pocket Maximums, by Plan Type, 2010



SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

\* Distribution is statistically different from All Plans distribution ( $p < .05$ ).

Note: Distributions are among covered workers facing a specified limit for out-of-pocket maximum amounts. HSA-qualified HDHPs are required by law to have an out-of-pocket maximum of no more than \$5,950 for single coverage and \$11,900 for family coverage in 2010.

